

MAR 20 1926

VOL. V

OLD SERIES VOL. LXXXII

Medical Lib

No. 3

THE
AMERICAN
JOURNAL OF PSYCHIATRY

(FORMERLY THE AMERICAN JOURNAL OF INSANITY)

UNDER THE AUSPICES OF
THE AMERICAN PSYCHIATRIC ASSOCIATION

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BALTIMORE
THE JOHNS HOPKINS PRESS
JANUARY, 1926

Published Quarterly

Subscription, \$5.00 a Volume

Entered as second-class matter July 31, 1911, at the postoffice at Baltimore, Maryland, under the Act of March 3, 1879.
Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917.
Authorized on July 3, 1918.

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AMERICAN JOURNAL OF PSYCHIATRY

THE LABORATORY METHOD IN PSYCHOANALYSIS, ITS INCEPTION AND DEVELOPMENT.*

By TRIGANT BURROW, M. D., PH. D.

With the new basis of thought and procedure which emanated from the evolutionists there was introduced into scientific method a new instrument for the determining of scientific processes. This instrument is the scientific laboratory. The distinction of the scientific laboratory is its precision of judgment with respect to the data under investigation. In order to understand the meaning of the laboratory as applied to our own subjective processes, we shall be helped if we will first demand of ourselves that we understand more clearly what is the meaning of the laboratory as applied to its commonly accepted objective materials—if we will ask ourselves just what the mind requires of itself and determine definitely what are its criteria in entering upon the method of the laboratory. Until we recognize the processes of mind that determine the function of this instrument of precision we shall not be able to adhere to the uncompromising criteria that everywhere characterize the discipline of laboratory procedure.

The laboratory presumes a basis of observation that rests upon a principle that is phyletic and inherent. In the absence of this phylogenetic basis there is no biological observation because there is lacking the underlying principle of all laboratory procedure. Through this principle the laboratory establishes a method of comparison whereby the particular element of the species is seen in relation to its phyletic substrate. The study of comparative anat-

* Paper read before the Ninth Congress of the International Psycho-Analytical Association, Bad Homburg, Germany, 1925.

Paper to appear in its German version in the Internationale Zeitschrift für Psychoanalyse.

omy demonstrates that the elements of a species represent a phyletic continuum that forms a common basis for comparison throughout the elements of the species in question. Blood platelets are scientifically recognizable as blood platelets because of their structural identity or generic consistency. Likewise the pathology of a structure or tissue is recognized as a deflection from the norm because of its divergence from recognized healthy elements. But, owing to habitual inadvertences of outlook traceable to man's personal inhibitions, there has not as yet been recognized within the mental or functional sphere the primary continuum that constitutes the substrate of individual life and that makes possible the recognition of pathological divergences. It has not been recognized that under the conditions of our complex society these divergences exist throughout the species as a whole.

Within the subjective sphere—the sphere of man's own inherent thought and function—Sigmund Freud was first to employ a laboratory technique through the application to consciousness of dynamic biological principles. The introduction of this dynamic factor marked the beginning of the scientific method within the unconscious sphere of our human behavior. Thus it was in the hands of Freud that the scientific instrument afforded by the method of the laboratory came to be utilized within the sphere of man's mental processes. But this innovation of Freud's within the subjective sphere, paralleling, as it does, principles long recognized by science in the objective sphere, has been socially opposed by obstinate inhibition on the part of the human organisms whose habitual prejudices, social as well as personal, were necessarily affronted by this laboratory scrutiny. These inhibitions, contrary to our common interpretation, are by no means confined to those outside our psychoanalytic ranks. They are also operative among those comprising our own number.¹ Indeed it is precisely within ourselves as psychoanalysts that the real impediment lies. And it is this impediment which has automatically diverted us from the original laboratory intention of Freud.

It is my position that because of this resistance intrinsic to ourselves, the indispensable instrument of science, namely the labora-

¹ "Psychoanalytic Improvisations and the Personal Equation," paper read at the Fifteenth Annual Meeting of the American Psychoanalytic Association, Richmond, Va., May 12, 1925.

tory of scientific research, has yet to come into its rightful place among us. In order to arrive at a phylogenetic substrate within the mental sphere, we need to observe the unconscious from a social basis of technique that is analogous to the individual basis of technique originally applied by Freud to the individual neurosis. For if we will observe the unconscious from a social basis, we shall find, I think, that there is the need for a laboratory study of consciousness in its social mechanisms that corresponds to the study of consciousness in its individual mechanisms. We shall find that there is the possibility of a laboratory approach to distortions of consciousness existing socially that is identical with our approach to the mental distortions which through Freud we first learned to recognize in the unconscious processes of the individual patient.

Though the development of Freud's thesis introduced into science the possibility of a laboratory method with respect to man's mental processes, psychoanalysis continued to be consistent with its medical tradition of the clinic. Having had its inception in the clinical approach it was inevitable that psychoanalysis should adhere more and more to the therapeutic method of the clinic and depart to the same degree from methods pertaining to the technique of the laboratory. As a result of this unperceived circumstance the tendency has been for psychoanalysis to wander so far from its original basis of research as now to require very exacting processes of reconstruction if we are to restore it to the scientific postulates that originally underlay Freud's basic discovery. Sensing the need for a more encompassing procedure, my students and I began to center our interest upon methods that would insure a greater precision of laboratory technique. With my associates I came to realize the necessity of applying under conditions of actual laboratory or group analysis the method which Freud had developed in the treatment of individuals. The outcome of our work has been the gradual recognition of the necessity to base the processes of our observation upon methods involving a social or consensual technique that is as definite as that of the laboratories of objective biology.³ For as the objective criteria of

³ "Psychiatry as an Objective Science," paper read at the Fifteenth Annual Meeting of the American Psychopathological Association, Washington, D. C., May 7, 1925.

the laboratory reside in a consistent continuum or phyletic substrate comprising the species, so its subjective criteria are equally indispensable and reside equally in a subjective continuum that unites the subjective processes of the several observers. Consensual data are only recognizable through a consensual basis of sense impressions. Thus it is becoming more and more evident that, in the absence of a social recognition of the need among us of this social instrument of precision, we are as psychoanalysts unconsciously lending our support to social dissociations that are as definitely unconscious substitutions as the symbol substitutions which we have come to study clinically in the underlying displacements within the unconscious of the individual.

In a paper read before the American Psychoanalytic Association in 1917* I attempted to establish a principle representing, in what I spoke of at that time as the "nest instinct" or the "pre-conscious," the primary subjective phase of man's mental life. This principle was posited with a view to the recognition of a biological, phyletic continuum in relation to which might be compared not only individual correspondences but also their divergences in pathological reactions.

In its original position this early principle of primary identification had significance merely as an accidental, isolated laboratory finding, and was limited in its application to the individual neurosis. As an isolated phenomenon it was, in its ontogenetic significance, necessarily applicable alone to an ontogenetic or individual basis of analysis. But, because of the evident approximation of this principle to that which is fundamentally organismic or phyletic, it quite inevitably led to wider phylogenetic bases of inference. It is interesting that in its ontogenetic bearing this principle of primary identification has been fully substantiated analytically not only by my own studies of dementia præcox and adjacent disorders but also by studies made by Dr. L. Pierce Clark in the psy-

*"The Preconscious or the Nest Instinct," paper read at the Seventh Annual Meeting of the American Psychoanalytic Association, Boston, Mass., May 25, 1917. This paper forms the nucleus of material that is being gathered into a book subsequently to be published. Preliminary reference to this principle was made in the "Genesis and Meaning of Homosexuality," paper read at the Fourth Annual Meeting of the American Psychoanalytic Association, Albany, New York, May 5, 1914. Published in *The Psychoanalytic Review*, Vol. 4, No. 3, July, 1917.

chology of essential epilepsy and kindred manifestations.⁴ Basing his observations on the principle of primary identification, Dr. Clark has also definitely traced to this source the equally organic reactions embodied in the psychoneural regressions of the epileptic. But, as I have said, while the divergence represented in the individual neurosis is traceable to this principle of primary identification as the original substrate of mind, its application is adequate only to the individual analysis. But man is not an individual. His mentation is not individualistic. He is part of a societal continuum that is the outgrowth of a primary or racial continuum. As the individual finds his basis in an individual continuum with an ontogenetic matrix or maternal source, so the social organism has its basis in a continuum with a phylogenetic matrix that is societal or racial. It is my thesis that this racial continuum is the phylogenetic basis of man's societal life precisely as the individual's early continuity with the maternal organism—his primary identification with the mother—is the ontogenetic basis for his subsequent development as an individual. In brief, just as we may trace the mental life of the individual to a physiological source corresponding to this primary identification, so within our societal life we may trace man's common source to a principle of primary identification that is racial.

In recent years the attempt has been made on the part of myself and a few students to establish a means for the practical recognition among us as individual organisms of this common substrate of feeling and reaction first posited theoretically under the symbol of the preconscious. Regarding this preconscious principle as the phyletic basis of individual mentation, it has been our practical endeavor to relate individual manifestations to this common racial principle shared among us and to study the pathological divergences of our various feeling reactions in the light of this common feeling continuum. The result has been the establishment of a practical laboratory of psychoanalysis in which a consensual agreement

⁴ Clark, L. Pierce. "A Psychologic Study of Abraham Lincoln," *The Psychoanalytic Review*, Vol. VIII, No. 1, January, 1921; "The Narcism of Alexander the Great," *The Psychoanalytic Review*, Vol. X, No. 1, January, 1923; "Some Psychological Data Regarding the Interpretation of Essential Epilepsy," *The Journal of Nervous and Mental Disease*, Vol. 61, No. 1, January, 1925.

concerning the subjective material has rendered possible an exact observation of individual deflections precisely as the laboratory of structural biology has made possible the scientific observation of structural divergences from a commonly accepted phyletic norm. Under this laboratory discipline reactions which, in accordance with the personal technique of psychoanalysis, are studied in private confidence from a necessarily private basis of observation, have come to be observed commonly among a consensus of individuals recognizing and sharing among themselves a common basis of comparison. In this laboratory approach the method of psychoanalysis no longer confines itself to the study and treatment of an isolated individual by another individual who, through his private function as an analyst, is no less isolated. But the social repressions common to the social consciousness or to groups of individuals, presumably united within the confederacy known as normality, come equally under the challenge of a scientific laboratory analysis.

As we have said, the criteria of the objective laboratory of biology reside in a structural basis among the organic elements that is phyletic and continuous. Concomitantly, the criteria of the subjective laboratory of biology reside in a condition of continuity that equally unites the processes of the individuals or elements comprising the several observers. But in the subjective field the individuals who observe are the objects observed as well as the subjects observing, and just as the basis of observation in the objective laboratory resides in a homogeneity of objective sense impressions among the observers, so in the subjective sphere the test of accurate observation depends no less upon a homogeneous basis or continuity of the subjective sense impressions among the several observers. In this interpretation the method of the laboratory becomes the method of consensual observation no less in the subjective than in the objective sphere. For this consensus of observation establishes the conditions for dependable scientific judgment in that it precludes the element of personal bias with respect to the data observed. In all subjective experiment, therefore, the requisite condition for its proper conduct is the elimination of this personal equation and its necessarily deterring influence upon processes that determine the observation.

By virtue of the inclusive basis afforded by this consensual laboratory approach, psychoanalysis may come to occupy the same broad relation to mental disorder that medicine elsewhere represents with respect to disorders within the structural sphere. It has been the merit of the laboratory study of tuberculosis or typhoid fever that these abnormal processes have now come to be envisaged in their social or collective implications. These disorders were formerly quite isolated personal conditions calling only for isolated and personal treatment on the part of the individual physician. But by virtue of the evolutionary and phyletic basis provided by the structuralists, with their instrument in the laboratories of histology and bacteriology, these disorders are now studied in their social significance and receive the recognition that makes possible their study and treatment from a social as well as from an individual basis of outlook.

The time has come when the laboratory method initiated by Freud through the principle he applied to the study of the individual neurosis must extend itself to the larger application envisaged by a laboratory study of the neuroses in their wider social implications. The neurotic is no more an isolated phenomenon than the tubercular. In both, the ontogenetic nature of their disorders has its counterpart in a phyletic substrate that is societal. Accordingly, the process of their therapeutic adjustment cannot be met upon a basis that is restricted to an ontogenetic source but must extend itself equally to a source that is societal and phyletic. With the recognition of the socially continuous or communicative nature of infectious diseases there was made possible an inclusive laboratory study of the common source of these disorders and the tracing of this source to the common continuum of tissue represented in the healthy phylum. Correspondingly, with the recognition of the socially continuous or communicative nature of neurotic diseases and the tracing of their common origins through proper laboratory inquiry, there is made possible the recognition of the common source of these disorders within the sphere of consciousness.

Thus, after twelve years devoted to psychoanalytic work based upon the method of the personal analysis, it became apparent to me that the personal basis of the individual analyst is necessarily but the social counterpart of the presumably isolated reaction of

the individual before him. I began to realize that no theory of the common or phyletic nature of neurotic processes could offset the quite contradictory ontogenetic basis of actual procedure whereby my patient became closeted with me, as it were, in our confidential contemplation of his private inadvertences. It became apparent that the ontogenetic basis upon which the personal analysis inevitably rests necessarily excludes the consensus of judgment that is coterminous with the phylogenetic principle of consciousness. In the absence of this consensual basis requisite to laboratory precision of judgment the factor of the personal equation of the analyst necessarily operates unconsciously to inhibit more or less the direct and unprejudiced estimate of the data submitted.

It is this element of the personal equation which only a group or inclusive analysis is competent to challenge. Under its discipline we shall find that within the restrictions of the private analysis it is inevitable that this element of the personal equation unconsciously influences the personal judgment of the individual analyst. It is my position that because of this factor of the personal equation on the part of the analyst, the repression and personal secrecy that characterize the patient's neurosis can never be completely eliminated as long as we confine ourselves only to the personal process embodying the confidential rapport between patient and analyst. From a more inclusive societal approach such a type of rapport, with its necessarily individualistic limitation, may be recognized as an added factor in the repression and secrecy already dominating the unconscious of the individual patient. In short, it is too often the snare of the private analysis, as it is too often the snare of marriage, under our present social system, that it unconsciously substitutes for the isolated neurosis of the individual a socially reciprocal relationship that is no less secret and repressed in its mutual exclusiveness. This disclosure exposes a condition that is the embodiment of a social neurosis shared unconsciously by physician and patient, the mechanism of which consists in an unconscious pooling in a mutual situation of what had been the individually closed psychic compartment of each. It was the recognition of this mutual element of the personal equation that led to the gradual opening among my associates and myself of this secret and unconscious social situation.

The very natural culmination of such reflections as these was the quite spontaneous development of practical measures that led gradually to the establishment of a social or group method of analysis on the basis of a consensual laboratory technique. It may be of interest to mention briefly something of the actual situation that first led to our group basis of analysis. One of my patients, a student of unusual analytic insight and training, sensing the incongruity in the situation, challenged the discrepancy between my theoretical statements regarding our socially common basis of consciousness and the individualistic position which, as an analyst, I arbitrarily continued to maintain. I was straightway caught up by his protest against the inconsistency of these conflicting positions and by the interest this recalcitrant attitude seemed to me to offer experimentally, though unconsciously I was still skeptical of its practical value. And so I reluctantly agreed to an arrangement whereby the student should become the analyst and I the analysand, it being presumed that the social basis I advocated only in theory would be adopted actually and without prejudice by him. The arduous months of this experiment served only to prove that the patient's opposition to the inconsistency of my personal method was actuated by an equally personal and inconsistent method on his part and that the theory of a social approach to individual consciousness was, from the unbiased point of view of the laboratory, no more actual in his case than in my own. This finding led to a further extension of my experiment which consisted in the gradual development of a technique involving groups of individuals, first smaller groups and finally larger, the smaller groups consisting of as few as four, the larger of as many as twenty individuals. In such groups there was abrogated entirely the distinction between analyst and analysand, each individual automatically becoming both. There was here presented a social continuum of affects, and the need was a common recognition of their social basis in our common societal phylum. The gradual result of our group inquiry was the reluctant exposure of social repressions that are as definite as the presumably personal repressions that have hitherto occupied us as individual analysts. This became the more apparent in the circumstance that individuals who have undergone an individual analysis because of their personal resistances and who represent presumably analyzed personal-

ities are, when subjected to the more inclusive inquiry of a group analysis, still the victims of repressions having their seat in the collective repressions of our social life.

Perhaps the work of our group can best be described as the development of a social technique in the handling of problems which, being personal or ontogenetic, are equally social or phylogenetic. From the basis of a common societal accord we have tried to secure conditions which permit an objective evaluation of the unconscious elements socially represented by each of us in his single isolation. The situation was from the first difficult even to envisage. The reason is, as I see it, that the individual with all his personal subordination to the social system about him is at the same time an integral and necessarily contributory part of this same unconscious social organism. At one and the same time the individual is both victim and aggressor. He is at once both the aggrieved and the offender. And the effort on the part of our group to reunite these two artificially separated trends represented for many months an almost insurmountable difficulty in our work. In spite of its difficulties the outcome of our group work has been the development of an analytic technique that grants to the individual a perspective upon these inhibiting social conditions and materially enlarges his outlook as well as his possibilities of function as an element in man's homogeneous social organism. We have been able to demonstrate that there exists a definite and as yet unrecognized confederacy of self-protection and resistance throughout the social system that is as definite as those of the individual, and it has been shown that in this social consolidation of repression we are all equally unconscious constituents. But it has become clear that, in spite of this mass fixity and its stolid resistance to self-inquiry, these processes are as susceptible to definite analysis and resolution as the equally stolid resistances we have learned to recognize through our analysis of the reactions of the individual patient.

It is the authority of the laboratory that its basis is evolutionary and phyletic. In a broad phyletic encompassment it may be said that through the application of the principles of biology to the objective or structural sphere, as demonstrated in the laboratory, science and evolution have become synonymous. It may be as truly said that within the subjective field of inquiry the authority of

all scientific investigation resides alone in the laboratory. Submitting to this authority my associates and I have been forced to accept a phyletic basis as the structural continuum of consciousness in which individual men represent organically identical elements. Accordingly, our group work has endeavored to envisage the artificial differentiations and dissociations comprising the neurosis from a principle which being ontogenetic is of necessity phylogenetic also. For it is obvious that in our complex society these artificial differentiations and dissociations have ruthlessly separated and distorted not only the single individual within himself but the integral organism uniting all individuals in their common societal consciousness.

I well recognize that this position frankly questions the completeness of our present psychoanalytic basis, that it is the frank acceptance of the fact that psychoanalysis has reached a definite impasse. I feel we must face the circumstance that psychoanalysis has been concentrating its efforts on improving methods of applying its principles rather than on the development of the principles themselves. The approach presented in this paper, which recognizes the individual not as an individual but as part of a common societal organism, has by actual experimental test provided an instrument for the wider development of our essential psychoanalytic aims. The work of our group is not a theory of social values or a prescription for the betterment of social institutions. It is the definite analysis of social values and social institutions as they exist. This consensual approach is not a theory any more than the private approach to the neurotic individual is a theory. It is an investigation, and what we are insisting upon with respect to social groups is this recourse to investigation, not a theory of what social groups should be or might become. We can only reply to our critics as Professor Freud has from the beginning time and again replied to his critics. Said Freud, in effect: "Do not argue with me as to the nature of my findings but go directly to the source to which I have had recourse and where you may establish your own findings." For it was Freud's position that there exists something in human life that is definitely in need of investigation. This statement that Freud has applied over and over again to the individual needs now to be applied as insistently to the mass expression of consciousness represented among these same individuals in their collective social life.

PSYCHOTIC CHILDREN: TREATMENT AND PROPHYLAXIS.*

By A. A. BRILL, M. D.

This presentation is of a purely clinical nature, its purpose is to pursue the development of some psychotic children into adult life with the object of studying reaction types and of drawing some conclusions, speculative perhaps, concerning treatment and prophylaxis. Some of the cases in question have been observed for over 15 years; they were originally diagnosed as psychotic or neurotic depending on their erstwhile behavior and after these many years there is no reason for changing the diagnosis. They have all been running true to the respective type although some have made very good adjustments.

CASE I.—In the fall of 1909 I was consulted about a little girl of four and one-half years who according to her father had been very nervous for a number of weeks. The symptoms enumerated were those of resistive tantrums. The father stated that for a number of weeks she showed a definite change in her behavior. Having always been somewhat reserved and timid yet tractable she now behaved in the opposite manner. She was hypersensitive and irritable, she cried and moaned for hours at a time over trifles and could not be appeased, she often refused nourishment and returned to childhood ways in matters of cleanliness.

On my first visit I was at once reminded of the catatonic behavior one often sees in the state hospitals. She sat in a corner of the room with her head bowed, knees drawn up but as soon as she noticed me with her father, she became resistive and surly, repeating over and over again, "I don't want to say hello, I don't want to say hello." She continued this in a stereotyped manner until we interrupted her. Her father explained that this meant to express that she would not greet me as she always was taught to do at the appearance of strangers, and he added that since her illness she invariably refused to do whatever was expected of her. This little patient acted in every way like a catatonic *præcox*. She showed marked active and some passive resistances, negativism, mannerisms, stereotyped expressions and many hysterical reactions. Thus when forced to take food she would vomit but would often eat when not observed. With the beginning of her illness she began to wet the bed and refused to empty her bowels and was generally very careless in her habits. Here I was confronted for the first time since

* Read at the eighty-first annual meeting of The American Psychiatric Association, Richmond, Va., May 12, 13, 14, 15, 1925.

I left the hospital with a case of catatonia in a child which could not be treated like a hospital case. Something had to be done, as punishment and medications have already been tried without any effect.

The family history was not good. The mother was heavily burdened by heredity. She had a *præcox* brother and as I found out later she was subject to schizoid manic attacks. Further investigation showed that this change in the patient's behavior came very soon after her mother left the home. The parents never lived well together. The father was a well balanced conservative type, while the mother was very unstable emotionally, she had a "Greenwich Village" philosophy so that it finally came to a complete break in the family relations. The mother left her home, and the three children of which the patient was the youngest were put under the care of a sort of governess-housekeeper. I gathered that the other two children readily adapted themselves to this new mother while the patient developed a marked peevishness and resistance from the very beginning, culminating in the symptoms described. I interpreted the child's behavior as a disturbance in her sexual life in consequence of the breaking up of the family; she was unable to adjust herself to the new mother whose general temperament and behavior was undoubtedly just the opposite of her own mother, a purely psychogenetic Freudian interpretation. I naturally reasoned that if the child could have her mother it would help, but when I expressed my thoughts to the father he firmly insisted that this was impossible. The mother had committed an unpardonable crime, a suit for divorce was pending and he could not allow the child to be with her, but finally the grandparents prevailed upon him to consent to the experiment. Without going into many details I can state that the child showed an immediate improvement and within a few weeks lost all the symptoms enumerated.

But as the patient had always been somewhat sclerotic as far as adjustment is concerned, and although the symptoms apparently disappeared, I did not conceal from the parents my apprehension about her future. I felt that in her childish way she went through a catatonic *præcox* episode and wondered what would happen to her when she reaches the *præcox* age. The father fully realized the problem and has followed my suggestions up to the present. The patient is now a nice healthy college girl of twenty years and although she is a schizoid of Kretschmer's pykinical type her parents and friends find nothing wrong with her. Thus far she faced successfully all the vicissitudes of pubescence and has made an excellent adjustment. I have no apprehension about her future.

CASE II.—The obverse of this picture will be shown in the following case: I saw S. six years old, in December, 1908. Her parents were well-to-do society folks who gave very little time to their two daughters, the patient and her younger sister. I was consulted because the child showed frequent outbursts of temper and was very jealous of her younger sister, openly wishing her death. She was very obstinate and resistive and had bad habits (masturbation) this was really the main reason why I was called in consultation. Here too we were dealing with a catatonic type. The little girl

was very negativistic, refused to co-operate with the servants and as she saw little of her parents, there was hardly any rapport between them. To show what an obstinate child the patient was, the mother related that when she was about three years old her nurse who had been with the patient since her birth was sent away and replaced by a governess more suitable for the child's age. The patient reacted to it so vehemently that after a few weeks' struggle, during which time the child was extremely petulant, hardly taking any nourishment, the mother was forced to take back the old nurse.

As all my young cases have already been thoroughly examined and found to be well physically I confine myself to the mental and emotional sides of the patients. As a rule I see the patient as little as possible, the doctor habit is not good for these types. I observe the patient long enough to make my diagnosis and then proceed to investigate the child's home life. In this case I had the co-operation of a very able psychiatrically and psychoanalytically trained woman who studied the home situation and consulted with me daily. The parents soon¹tired of co-operating with us, although wealthy they felt the financial burden of the treatment and decided to take matters in their own hands. In fact the father boasted to the friend who recommended me to him that with the strap he did in a few days what it would have taken me months to do. In 1921 the girl had to be sent to a sanitarium, she is suffering from schizophrenia.

Most of the cases that I have in mind were preponderatingly schizoid, some, however, showed a pronounced syntonic picture as shown in the following patient:

CASE III.—C., a boy of five, was seen by me when he was five years old. The history stated that he was apparently well until about two months before when he became excited after witnessing the slaughtering of a chicken. From what I could gather the boy became very excitable as soon as he saw the chicken killed and acted like a patient in a manic excitement. His symptoms repeated themselves in attacks lasting from a few hours to a few days. He was then very restless and agitated, talked rapidly, almost flightily; he paced the room, called for his mother, cried and sometimes shouted, and at times he showed elementary hallucinations during which he reproduced the episode of the slaughter. I was not sure at first whether to call him a case of hysteria or of manic excitement but finally decided for the latter diagnosis especially as there was a manic family history. I have known him for almost 16 years. Judging by his behavior during those years, I have no doubt that he is a manic type and that his erstwhile attacks were of the manic depressive type. This

patient has had no attacks since those described and I feel confident that he will have none in the future.

CASE IV.—A similar case is J. whom I met 15 years ago when she was four years old. She was a very active masturbator and was subject to moody attacks, elation and depression which were clearly recognized by her parents. Thus when her nurse was sent away when she was a little over three years she threatened suicide saying, "I'll die myself when Mamy (nurse) goes away." Here too the reactions were decidedly manic and her history up to date fully confirms the diagnosis.

Many other cases could be cited whose career I have followed for about 15 years, I could also mention any number of young people whom I have known intimately for over 10 years. Those given were selected at random out of the first 14 cases from my records. All of them have been considered mentally normal, some even precocious, most of them were somewhat difficult to manage, from early childhood they showed either emotional instability or marked emotional rigidity. Considering them under the light of the more recent formulations one can say that they were either preponderatingly schizoid or syntonio.

Without going into a discussion of these formulations,¹ I wish to say that it is my feeling that we have reached a stage in psychiatric diagnosis where one can speak of tendencies just as one does in physical diagnosis. And just as in physical states, given an average endowment, good or bad health depends on the environment so it seems to be in mental health. To follow the analogy still further we venture to say that by recognizing an exaggerated emotional state in early life one can produce a sort of immunity for subsequent schizoid or syntonio disturbances, almost in the same manner as in the case of physical conditions. I have a strong feeling of conviction that the patients mentioned if they had been left to themselves they would have broken down mentally and emotionally at puberty, as in the case of S. whose parents resorted to corporal punishment in order to overcome her schizoid resistances. I might add that, bearing in mind the etiological factors as formulated by Freud, one could predict a future nervous or mental break-down with as reasonable a certainty as in the case of physiological indications. From a very large material at my disposal I will cite the following illustrative case:

¹ Cf. Barrett, Constitution and Disposition in Psychiatric Relations, AMERICAN JOURNAL OF PSYCHIATRY, October, 1924.

I have known this 10-year-old patient since he was about a year old. His parents are healthy people of the over-cultivated type. The mother is neurotic, aggressive, and pedantic, while the father is a genial, good-natured business man. I visited the family in their country home, when the boy was about two years old and I observed the following incident: The little fellow played in an enclosed porch, when his mother appeared and told him to put his toys away and come for his supper. The boy was seemingly very hungry, for he jumped up and made an attempt to run into the nursery, but his mother stopped him and commanded him again to put his toys where they belonged. The boy refused, screaming for his food and the mother was just as obdurate in her demand, her son had to be trained into an orderly man. The scene impressed me, because the child displayed a very marked emotional outburst, he was terribly angry, he screamed, stamped his little feet and acted as if he could kill his mother, but the latter held her ground until the little boy obeyed. I wondered at the time whether such an episode left any impression in this boy. I spoke to the mother about childhood impression and disapproved of her method of training. I felt that she was too insistent, that her way evoked great outbursts of resistances in the child towards her and expressed the idea that it might injure his relation to her and to the world in later life. I was not consulted any more, but for years I heard that the boy developed into a very bright pupil. Recently, however, he was brought to me by his mother because he has been acting in a nervous manner. Due to admonition uttered by me eight years ago the mother first consulted another physician but finally decided to return to me. The patient had been a problem for over a year, although intellectually above the average he did not get along in school, his deportment gradually grew worse so that he had recently been threatened with expulsion. At home he acted in a similar manner, he told many lies, stole some money on a number of occasions and evinced a rather peculiar behavior towards his mother. On the one hand he was very attached to her and on the other hand very resistive (ambivalence). To put it in her own language, "He is always trying to get my goat, when I say yes he is sure to say no." The most interesting neurotic symptom that he showed since the age of eight years is the following: His parents noted

that he suddenly started to act very offensively to the female servants. He would brusquely command them to do things, he would shout at them that they were servants and must do his bidding, and continually behaved in a way that the servants refused to remain in the house. How he came to act this way the mother could not understand as she and her husband have always treated their servants with the greatest consideration. As she spoke I recalled the episode of eight years ago and I reminded her of the treatment she accorded him from his early childhood. I explained that by her pedantic insistence that the child must follow her bidding to the letter of the law, she kept alive and even enhanced his algolagnic component, and that now when he is in the prepubescent state he follows this path to get a sadistic outlet¹ from women who undoubtedly are mother substitutes.² The mother corroborated my explanation by many examples. It is of interest to note that as he is now 10 years old and realizes that he cannot always act frankly about his feelings he resorts to the usual forms of distortion. Thus a few weeks ago he was confined to bed suffering from a bad cold. His mother passing the sick room heard him shout all kinds of commands to his trained nurse. The mother was astonished at his boldness, as he knew this nurse only a few hours. Just then the nurse came out of the room and explained to the mother that her patient asked her to play with him a game of King and Slave and that his vociferous commands were not to be taken seriously. Now children's games are usually efforts to put in operation unrealized wishes, this is especially true of plays invented by the children themselves. Here, of course, it was simply a case of gratifying a sadistic desire in a hidden manner. The patient clearly identified the nurse with his mother³ but as he could not openly behave towards her as he does to the servants, he concealed the situation by asking her to play the game of King and Slave which he invented for the occasion.

¹ Freud: Three Contributions to the Theory of Sex. Monograph Series Journal of Nervous and Mental Diseases Publishing Co.

² Those who are familiar with the Freudian identification mechanisms will understand why the boy began to act in this manner at the age of 8 years.

³ Nurses are mother substitutes *par excellence*.

I could multiply this illustration by many others of a similar kind in which the causal factors of a later neurosis or psychosis were directly observed by me or were furnished by parents. Indeed many years of study have impressed me with the conviction that in a certain constitution the development of a neurosis or psychosis is simply a question of environment, and that the time has come when one may speak about mental and emotional tendencies for psychoses and neuroses and have in mind children who, unless properly adjusted, will in all probability develop psychoses and neuroses, and that such tendencies manifest themselves in preponderating schizoid or syntonic reactions in the sense of Kretschmer and Bleuler.*

There are surely other types concerning which we do not as yet know enough. By proper adjustment we mean that an effort be made to integrate and stabilize the exaggerated schizoid and syntonic factors in such children. This brings us to the question of treatment which can only be done through the psychoanalytic approach with a thorough knowledge of psycho-sexuality in the sense of Freud's Three Contributions to the Theory of Sex. One must not forget that the difficulties manifested by our adult præcox and paranoid patients as we see them in the hospitals center around their psycho-sexual life and hence it is only natural that we should pay special attention to the sexual development of the child. Whenever one examines an acute or chronic schizophrenic or listens to the productions of a manic one invariably finds the erotic in the foreground. The nucleus of all these psychoses just as of the neuroses is a psycho-sexual maladjustment in childhood and it is my conviction that if no accretions were formed around it there would be no psychoses or neuroses. In making this statement I am not at all unmindful of the physical factors that one often encounters, but they alone never produce a neuroses or psychoses of the functional type; there were no such factors in the cases enumerated. Such patients cannot, however, be treated like adults, *i. e.*, they do not need a *lege artis* psychoanalysis. As a rule the treatment was carried out by the mother who reported to me from time to time or when feasible was analyzed herself. Sometimes it was done by the father or by psychoanalytically trained

* See Brill, Schizoid and Syntonic Factors in Neuroses and Psychoses. AMERICAN JOURNAL OF PSYCHIATRY, April, 1925.

women. To be sure I cannot give you here the analysis of the cases. I followed the model of Freud's Kleiner Hans and the results were invariably good. In fact children are easier to manage in this regard than adults. But ideal prevention in such cases must start with the parents, they should know how to manage their children which unfortunately is rarely the case, hence a bit of advice may not be amiss. If possible there should be no only children, no favorites, no undue coddling, no dishonesty on part of parents to children, and, last but not least, no conflicts between the parents. But if the schizoid or syntononic mechanisms crop up in sufficient numbers to create a disturbance in the average child the only rational management is through the psychoanalytic approach.

RESULTS OBTAINED BY THE INTENSIVE USE OF BROMIDES IN FUNCTIONAL PSYCHOSES.*

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In 1916, Ulrich, a physician in charge of an institution for epileptics at Zurich reported that he had successfully treated 10 cases of melancholia by the use of a salt free diet, and bromide given to the point of marked intoxication. More recently Kläsi employing a somewhat similar method, that of prolonged narcosis, has reported satisfactory results in the treatment of 26 schizophrenic patients by the use of somnifen (a drug similar in action to barbitol) and luminal. Aside from these two publications, no other works of a similar nature have come to my attention. Text books, in general, condemn the use of bromides in the treatment of mental disorders of the functional type, and no one so far as I am aware has hitherto attempted to make use of the plan suggested by Ulrich.

Having long felt that his work because of its apparent good results justified further investigation, and being confronted with a case of agitated depression that resisted all other forms of therapy, the plan of bromide intoxication was employed, and treatment was begun at the Utica State Hospital, June 18, 1924. But after treating two or three other cases in this manner the plan was abandoned, for we were convinced that while the method had some merit, it was too dangerous for general use. During the process of treating these cases, however, some observations were made on the action of the drug which aided us in devising a new method of treatment.

These patients, it was observed, besides being depressed were under great tension which seemed to be relieved by the administra-

* Read at the eighty-first annual meeting of The American Psychiatric Association, Richmond, Va., May 12, 13, 14, 15, 1925.

tion of bromide. But this relief was not obtained until considerable bromide was accumulated in the tissues. The plan, therefore, of giving large doses of the drug yet avoiding, as much as possible, its toxic features, suggested itself, and has since been employed.

At first only patients showing depression were treated, but in addition to the depression there were often also other features, such as wetting, soiling and destructiveness, which gave way while the depression was being treated.

Since many cases of dementia præcox, likewise, frequently show tension associated with habit disorders particularly at the vegetative level, a new field for investigation was indicated. Later, those showing outbreaks of violence were subjected to the same form of therapy, also with favorable results. In fact, the chronic, disturbed, untidy classes constitute a large percentage of the cases treated.

It is almost needless to state that without previous experience and without works of reference to guide us many difficulties in carrying out this form of therapy were, at first, encountered. But as knowledge was gained in regard to the complex action of the drug these difficulties were gradually overcome so that now distressing symptoms are rarely produced.

In presenting this subject it seems advisable to give the case records in considerable detail in order that a better understanding may be had of the types of cases treated, the reaction of the patient to the drug, and the condition of the patient before and after treatment.

The patients first selected for treatment were those who were most difficult to care for, and who had failed to respond to other forms of therapy. A few of the earlier cases showing the more striking effects of the treatment will be cited.

The first group consists of four cases showing particularly disturbances of the emotions.

CASE I.—M. P., an Italian woman, was admitted to the Utica State Hospital, January 2, 1923, aged 37 years. Her youngest son was fatally scalded. She grieved over this. Finally she became so self condemnatory, excited, and destructive that her commitment was necessary.

At the time treatment was begun she was in a state of marked agitation which had continued unabated for six months. She cried, screamed, wrung her hands, twisted door knobs and pounded the doors with her hands until

both palms and dorsal surfaces of hands were covered with thick calli. She could not be reasoned with and often she struggled to get out when the door was opened. Prolonged hydrotherapy produced no improvement. There was proclivitas with frequent wetting of the floor. She was poorly nourished, weighing only 85 pounds. Bromide treatment was begun on June 28. Two days later she was quiet and stayed in bed the greater part of the afternoon. The dose was promptly reduced, 20 to 50 grains a day, being given. Her improvement was gradual but with exacerbations of symptoms at times. Vaginal hysterectomy was performed on October 1. Fearing that she would die from the operation she again became somewhat agitated but became quiet within 10 days. She was paroled on October 24, 1924, and has since remained well.

CASE 2.—A mixed manic, showing stuporous features, and marked eroticism, is of interest from the fact that she was brought from a state of deep regression to practically a normal state in nine days of treatment. K. M., a woman, aged 32 years, was admitted to the Utica State Hospital, April 2, 1924. She had had four previous psychoses. All the attacks were sudden in onset. The first occurred at the age of 14 years; the fourth at 22 years; duration one and one-half years with recovery. She was married 3 months previous to the onset of the fourth attack. The fifth psychosis was sudden in onset, February 25, 1924. She imagined she was talking to her mother and others not present; alternately laughed and cried. On admission: A large, well-developed woman, in good state of nutrition. She was erotic, exhibitionistic, and onanistic. Later: Sullen, disinterested, irritable, untidy, wet and soiled clothing and bedding, masturbated openly, tried to make sexual assaults on men who visited the ward; often used vile language. She lay on the floor. Such was her condition when treatment was begun on September 27, 1924. She was given 360 grains of bromide the first day, and 300 grains the second day. At night on the second day when told to undress she replied: "I can't. I am too drunk, I feel as if I had been drinking whiskey." She undressed herself, however. Treatment was continued. On the third day she was pleasant in the morning, and answered questions; in the afternoon irritable and untidy in appearance. Not erotic. On the seventh day she was pleasant and agreeable and helped with the ward work. On the ninth day she went to the occupational therapy center. Two days later she said she had been sick, and had heard the voices of people at home and the voice of a baby calling her mother. (She has had no children.) She did not recall her peculiar conduct on the ward, however, and appeared not to know the physician whom she had tried to assault sexually. She showed no further mental symptoms and was paroled on October 24. She has remained well, both mentally and physically.

CASE 3.—The following case is of interest from the fact that the patient was quite dissociated, and very poorly adjusted to her environment before treatment was begun. M. H., now aged 46 years, was admitted to the Utica

State Hospital, July 7, 1919. She had a high school education and was a successful school teacher. She had been a widow for 16 years before admission. Temperamentally, she was jovial, though serious minded and rather head strong. Onset: At first there was double vision, followed by a left hemiplegia, six months before admission; Wassermann, 2 or 4 plus; recovery in a month. Later she was depressed and made suicidal attempts.

On admission, serological examination was negative. There were no neurological signs. Mentally, she was depressed and restless. She said her soul was lost because she was wicked; people here wanted to get rid of her and placed poisonous substances in the food to effect that purpose. There were no defect symptoms. A year later she was described as assaulting, destructive, resistive, and inaccessible. Later she was kept in bed and developed contractures of both legs. In July, 1921, she fell and received an impacted fracture of the left hip, which left her lame. In August, 1923, it was stated: "She is kept in a single room because she kicks and strikes other patients. Part of the night she is noisy." She said: "I am scared to death, I am awful. What are you going to do with me?" Henceforth she was given to explosive reactions. Every few minutes she would give vent to loud yelling, and often she made unprovoked assaults upon bed patients. Hydrotherapy was employed from August 4 to 21, 1924, but without effect. It was then discontinued and bromide was given. She showed a gradual improvement. On September 23 she was transferred to a quiet ward. Occasionally she would shout out but she would apologize for it and promise to do better. It was then learned that the shouting was in reaction to hallucinations of hearing. She said: "I struggle with these voices to control them until I am weak. I guess there must be a million of them. I would like to get well and go home." For a time she assisted with the work in the dining room, and she requested that her relatives call to see her. Previously she had not wished to see them. Because of the fact that she still continued to shout at times, it was necessary to transfer her to another ward. But she has never since made assaults. When questioned she takes a pessimistic view in regard to her future. She does not believe she will recover. From August 21 to October 24, 1924, she received 10,140 grains of sodium bromide in 57 days of actual treatment, or an average of about 178 grains daily. During that time she gained 10 pounds in weight (94 to 104 pounds). During the past two months (April and May, 1925) she has again been receiving about 240 grains of bromide daily with the hope of further improving her condition. Her present weight is 90 pounds.

CASE 4.—This case is important for the reason that in addition to the emotional disturbance there were habit disorders such as wetting, soiling, and destructiveness. B. M. E., a deportable alien, was admitted to the Utica State Hospital on March 30, 1923, aged 42 years. The onset of the psychosis, about two weeks previous to admission, was characterized by infatuation for a widower whose wife she had just previously cared for. She spent

\$500 on her trousseau and announced to all her friends that she was to be married after Easter. Soon she became so disturbed and uncontrollable that her commitment was necessary. On admission she showed marked psychomotor activity and elation with flight. At times she was violent and destructive. Presently she passed into a state of greater activity, in which condition she remained up to the time treatment was begun. Hydrotherapy was without apparent effect, as was also occupational therapy. When sent to the occupational therapy center she promptly tore the curtains from the windows, and destroyed the material used by the class. As a result she had to be kept on the ward. When out of the continuous bath she required the constant attention of a nurse to prevent her from destroying curtains, standspreads, and everything else within her reach. Dresses, shoes, underwear, and stockings were treated in like manner. At meal time she would wrench the handles from the cups, and conceal them. These pieces she would later use to dig the plaster from the walls, hence she had to be fed. Every night she would tear her blankets and bedding into strips; these strips she would pick into fine threads. Having taken her bed apart, she would hammer the doors and the walls of her room with it. As a result her bed was removed, and she was allowed only pads to sleep on. Besides being destructive, she was also very untidy. She smeared her room and her body, face and hair with feces. Treatment was begun August 15, when she was given 180 grains of sodium bromide. By the 21st of August she was receiving 300 grains a day. On that date she did not soil her room at night. On the 22d she asked the nurse to take her to the toilet. She soiled her room that night, but did not smear it. After about 10 days treatment she was given a bed, which she has, with a few exceptions, since had. Occasionally, especially when treatment is temporarily discontinued, she makes so much noise, jumping her bed up and down that it is necessary to remove it. She rarely now wets and soils her room, and she does not destroy bedding or smear herself. During the day, however, she remains exceedingly active, dancing and singing. With the exception of some improvement in habit disorders, such as noted, not much success has been obtained in the treatment of manic phases, hence bromide is now rarely given in these conditions.

The following group to be considered consists of three cases of dementia præcox who manifested disorders of conduct, such as irritability, destructiveness, and outbreaks of violence.

A. E., a case of dementia præcox, catatonic form, has been in state hospitals for 14 years. She was admitted to a down state hospital July 13, 1910, aged 20 years. On admission she was assaulting and resistive. She called herself the Virgin Mary and the Queen of Heaven. The continued notes, year after year, speak of violence, assaults upon other patients, destructiveness and untidiness. She was admitted to the Utica State Hospital on transfer January 10, 1923, where she continued as above described.

She preferred to sit on the floor. Attempts to move her resulted in attacks upon nurses whom she kicked, bit and scratched. She was sullen and kept as far away from the nurse as possible. She was unemployed. She had a habit of twisting her hair into small rolls which stood out like quills. Her speech showed marked incoherence. Physically she is of the athletic type of build. On September 9, 1924, she was given 300 grains of sodium bromide. During a period of eight days she received 1470 grains without obvious change in conduct. But by the 24th of September she had ceased to twist her hair. She no longer tore blankets and bedding. She did some hard work.

The treatment was continued with some interruptions until March 17. During that time she received from 180 to 210 grains of sodium bromide daily. Occasionally when treatment was stopped she would become over-active, and on a few occasions she tore her dresses. On the whole, however, there has been marked improvement in her conduct. She will now reply to simple questions, and what she says can be understood. Instead of being irritable when addressed, she is pleasant and smiling. She goes daily to the physical culture class, takes part in the exercises willingly, and does whatever she is told to do. On April 28, she again tore one of her dresses. Treatment was therefore resumed for a few days. Previously, it should be recalled, tearing blankets and dresses was a daily occurrence with her. The weight of this patient when treatment was begun on September 9, was 107 pounds. Her weight on May 1 was 110 pounds.

The second case, M. M., was admitted to the Utica State Hospital, 18 years ago. She is now 42 years old. Her psychosis existed for two years before admission, and was characterized by restlessness, excitability, and resistiveness followed by depressive episodes. For seven years she has been on a disturbed ward. Of these seven years it is estimated that she has been disturbed five years. The continued notes speak regularly of violence, destructiveness, filthy and untidy habits. She was kept in seclusion much of the time. When necessary to give her attention the combined efforts of three or four nurses were required. A nurse unaccompanied was usually roughly handled. She is a woman of large frame, and of great physical strength. Treatment was begun on September 12, 1924. She responded readily. Soon she became quiet, and agreeable, and with few exceptions has so remained. Instead of being kept in seclusion she now spends her time in the day room. Occasionally she shows some irritability, but a few doses of bromide are sufficient to quiet her. Since February 14, no conduct disorder has been shown. She is regarded as quite harmless.

The third member of this group, C. R., is of particular interest from the fact that after treatment was discontinued there were recurrences of delusions, and hallucinations of hearing, which for a time could be corrected by psychotherapy, but as adjustments failed, the recurring ideas tended to persist so that her return to the hospital became necessary. Under further courses of bromide treatment, however, the delusions and hallucinations ceased, she regained insight, and is again doing well on parole.

The psychosis had existed for about four years when treatment was first instituted. She was admitted to the Utica State Hospital November 7, 1921, aged 37 years, of average intelligence, efficient at her work. She was of the submissive type of makeup, being properly adjusted to her family. She disliked her father because he was too strict with her and did not allow her to go out as she wished to do. There is a history of two previous attacks lasting one year each, in which she was cared for at a sanitarium. These attacks occurred at the ages of 13 and 25 years respectively, and were characterized by talkativeness, restlessness, unruliness and abusiveness. There was complete recovery in each instance.

The present psychosis was gradual in onset, extending over a year previous to admission, and was characterized by irritability, and a tendency to find fault, and complain about everything. She became restless, disobedient, and finally so unmanageable that it was necessary to commit her. On admission she was relevant and coherent, but expressed no concern about her commitment, and showed no insight. She exposed herself, and acted in a silly manner. She said she was afraid her father might harm her. She believed she was being persecuted by her family physician. She thought her sister had had an abortion performed by this physician. She was committed, she believed, because her parents feared she might expose the true facts about her sister. Her mother, she claimed, had made some insinuating remarks about her character. Later she was described as abusive, using vile language. She improved somewhat, however, and was allowed home for a few days during the early part of October, 1922. In November, 1922, she was described as disagreeable and noisy. She complained bitterly of mistreatment. She did not think she was the daughter of her parents. Following that date she was kept on the disturbed ward, and there was no improvement in her condition up to the time treatment was begun. She would sit on a bench and pound her heel on the floor in one place until she had made a depression in the floor; again she would dig her heels into her stockings until she had torn them to pieces. She cursed and swore about her relatives. She called the nurses vile names. Often she would yell and scream at them. She answered voices almost constantly. If interfered with, she would strike other patients.

On September 10, 1924, treatment was begun. During the following week she received 990 grains of sodium bromide. On September 11, the hallucinations were less marked. On the fourth day she volunteered to help with the ward work. She made beds and combed the hair of other patients. She had done no ward work previously although she had been on that ward for 22 months. Her improvement continued without interruption. At the end of the week the hallucinations had ceased. She related how her conduct had been influenced by these imaginary voices, how she heard them day and night, and that she had believed she was speaking with the President of the United States. Treatment was then discontinued. On the 24th of September she was transferred to the open ward. She promised to tell the physician at once if the voices returned. Two weeks later when she asked to see the physician she had undergone a decided change. She was less

tidy, idle, and answering voices. The nature of hallucinations and their relationship to dreams was explained to her. She was advised to associate more with other patients. Henceforth she was industrious and sociable. Hallucinations of hearing and delusions were denied. There was insight. On October 25, 1924, she was paroled. Home conditions were not very satisfactory. Within a month there were recurrences of the trend at times. But on the day she reported at the clinic, she stated that the hallucinations had again ceased. She spoke of them as imaginations which she was trying to control. Later, however, she became somewhat disturbed and on January 28, 1925, was returned to the hospital. On her return she expressed a firm belief in the reality of her imaginations. But she showed no conduct disorder other than a moderate degree of restlessness. From January 30 to February 9 she received 120 grains of sodium bromide daily. The voices soon ceased. She went regularly to the occupational therapy center. From February 9 to March 1, she received 90 grains of sodium bromide daily. Treatment was then discontinued for three days. During that period she became somewhat restless. Treatment was resumed. She responded promptly, and henceforth remained quiet and industrious with insight. On April 4, she was again paroled and was given a prescription for bromide. She is working as waitress in a restaurant. Thus far (July 1, 1925), there has been no return of symptoms.

In order the better to illustrate the effect of the drug on certain types of emotional disturbances and conduct disorders, a few cases still under treatment will be cited. The quantity of the drug given daily is stated, and the changes in symptomatology following its administration are noted. Appended to a number of the case histories are the weights of the patients as recorded weekly from the time treatment was instituted up to May 2, 1925.

Since these patients had, as a rule, remained without essential change for considerable periods of time before being treated, the description of the condition in each instance is limited to that observed when treatment was begun.

A. M., aged 58 years, has been in state hospitals for six years. Diagnosis: Involution melancholia. She was agitated, depressed, restless. She said she had committed the unpardonable sin, and could not go to Heaven. She asked to be chloroformed, killed, buried. She spent most of her time in the toilet where she could be heard moaning and crying. She ran away from the interviewer. Bromide treatment: October 8 to 13, 180 grains daily; October 13 to 22, 300 grains daily. Then quiet, sat on the ward, asked for her medicine, said she felt better. During November she received 200 grains daily. The first three days in December, 240 grains daily, then stupid, sleepy. Bromide was discontinued from December 3 to 10. Again she became restless, hiding in bathroom, and crying. December 10, 11, 12, 90 grains daily. She became quiet and composed, and remained so until January 18. In five

weeks she was again restless, and agitated. She was given 90 grains a day for three days. She remained quiet for eight days. She was given 90 grains a day for seven days, and remained quiet for eleven days; 90 grains a day for five days, and remained quiet for eight days. During March she received in all, five doses of 210 grains each. During April two doses, one on the third, and the other on the tenth. She is still quiet. The drug has an immediate effect on her. She has lost 10 pounds during the treatment.

WEIGHT CHART.

Oct. 4.....	114 pounds.	Jan. 24.....	101 pounds.
" 11.....	115 "	" 31.....	102 "
" 18.....	119 "	Feb. 7.....	103 "
" 25.....	118 "	" 14.....	104 "
Nov. 1.....	118 "	" 21.....	100 "
" 8.....	117 "	" 28.....	100 "
" 15.....	116 "	Mar. 7.....	100 "
" 22.....	115 "	" 14.....	101 "
" 29.....	115 "	" 21.....	102 "
Dec. 6.....	111 "	" 28.....	101 "
" 13.....	111 "	Apr. 4.....	102 "
" 20.....	108 "	" 11.....	104 "
" 27.....	109 "	" 18.....	103 "
Jan. 3.....	105 "	" 25.....	103 "
" 10.....	105 "	May 2.....	104 "
" 17.....	100 "		

L. E., admitted May 9, 1924, aged 41 years. Diagnosis: Involution melancholia. On admission: Agitated, depressed, feared she would be murdered, cut up; she wrung her hands, pulled her hair, moaned, and groaned. A quite typical agitated depression. Condition unchanged at the time treatment was instituted.

Bromide treatment: September 10 to 15, 90 grains a day. She became quiet, and began to sew. September 16, and 17, 150 grains a day. Better, but at times agitated, restless, fearful. During October 100 grains a day. No change in condition. Bromide discontinued from November 1 to December 6, when the patient became very agitated, the same as on admission. December 6 to 15, 150 grains a day. Again, became quiet and comfortable. Bromide discontinued for one month, then restless and agitated, the same as before. January 10 to 14, 90 grains a day. She became quiet on January 15. She has not since been restless or agitated. From February 14 to 28 this patient received 60 grains daily. Since the early part of April she has been receiving 60 grains daily. This seems ample to hold her in a comfortable state. She does a little sewing on the ward, and some work in the dining room. Unless questioned, she does not speak of her delusional ideas.

In this case large doses (210 grains daily) at longer intervals, such as were employed in some of the other cases did not prove so satisfactory as the smaller doses given daily. Since treatment was begun this patient has lost 13 pounds in weight.

WEIGHT CHART.

Sept. 13.....	109 pounds.	Jan. 10.....	96 pounds.
" 20.....	109 "	" 17.....	102 "
" 27.....	107 "	" 24.....	102 "
Oct. 4.....	104 "	" 31.....	100 "
" 11.....	106 "	Feb. 7.....	100 "
" 18.....	106 "	" 14.....	97 "
" 25.....	103 "	" 21.....	98 "
Nov. 1.....	103 "	" 28.....	97 "
" 8.....	100 "	Mar. 7.....	97 "
" 15.....	99 "	" 14.....	98 "
" 22.....	98 "	" 21.....	99 "
" 29.....	98 "	" 28.....	95 "
Dec. 6.....	98 "	Apr. 4.....	96 "
" 13.....	97 "	" 11.....	95½ "
" 20.....	96 "	" 18.....	97 "
" 27.....	96 "	" 25.....	95 "
Jan. 3.....	93 "	May 2.....	96 "

A. H., admitted March 17, 1923, aged 40 years. Diagnosis: Dementia præcox. She was depressed, agitated, noisy, bit her finger nails, wished she were dead. In her talk she was child-like, and delusional. She said: "I wish I had a beautiful body. I wish I were an angel. The devil makes me do things. The devil is in me." There was no change in her condition for 18 months following her admission. She was unemployed.

Bromide treatment was begun October 15, 1924, 300 grains a day, for ten days, were given. She then became quiet and helped with the dining-room work. Bromide was discontinued for six days. By November 1, again restless. Two hundred grains a day were given for two weeks, then 150 grains a day for two weeks. December 1, dull, stupid, toxic. No bromide was given for four days and mental symptoms returned. Then 120 grains daily were given for 18 days. She was quiet, comfortable, employed. Nine days without bromide. January 1 to 15, 210 grains a day. She remained quiet for three days. January 18, 210 grains. Quiet for 15 days. February 2, 210 grains. Quiet for eight days. February 10, 210 grains. Quiet for ten days. February 20, 210 grains. Quiet for 11 days. She had three doses of 210 grains each, during March, and two in April—1st and 14th. One dose of 210 grains will now stop agitation from ten days to two weeks. She is still quiet. She has gained 15 pounds during treatment.

WEIGHT CHART.

Oct. 11.....	99 pounds.	Jan. 24.....	114 pounds.
" 18.....	106 "	" 31.....	114 "
" 25.....	107 "	Feb. 7.....	114 "
Nov. 1.....	109 "	" 14.....	113 "
" 8.....	107 "	" 21.....	112 "
" 15.....	110 "	" 28.....	111 "
" 22.....	106 "	Mar. 7.....	109 "
" 29.....	109 "	" 14.....	112 "
Dec. 6.....	109 "	" 21.....	114 "
" 13.....	111 "	Apr. 4.....	113 "
" 20.....	112 "	" 11.....	112½ "
" 27.....	114 "	" 18.....	114 "
Jan. 3.....	111 "	" 25.....	111 "
" 10.....	111 "	May 2.....	114 "
" 17.....	115 "		

J. S., admitted January 22, 1925, aged 42 years. Diagnosis: Involution melancholia. Duration of psychosis one year before admission. She believed that she had caused her mother's death. There were several suicidal attempts while at home. Following admission she continued depressed, and agitated, picked skin from face, arms, and neck, wrung hands, whined, moaned, groaned, wanted to die, was resistive to attention, tube fed.

Treatment was begun March 6, 1925, 210 grains. She was so resistive that the bromide had to be given through a tube. Next, 300 grains daily were given until March 27, before any signs of improvement were shown. Suddenly she became quiet and mute, but took food voluntarily. After medicine was stopped she remained quiet for 11 days. Then agitated. She was given 90 grains daily for four days without much improvement. The dose was increased to 120 grains daily for a week. She became quiet, and able to do a little sewing and reading. Since then she has been kept comfortable on 90 grains a day.

WEIGHT CHART.

Mar. 7.....	Resistive.	Apr. 11.....	95 pounds.
" 14.....	Resistive.	" 18.....	97 "
" 21.....	97 pounds.	" 25.....	96 "
" 28.....	97 "	May 2.....	96 "
Apr. 4.....	92 "		

E. C., admitted October 18, 1924, aged 40 years. Diagnosis: Dementia præcox. Panhysterectomy, 1924. Restless, agitated, fearful; believed she had killed her mother and father. She thought other women patients were men. She said: "Don't make me sleep with that man." She followed the physician about the ward begging and pleading not to be operated on.

Bromide treatment was begun, November 26, 1924, 150 grains. November 27, 28, 29, 120 grains a day. In four days she became quiet, not agitated, went to bed without fear, ate well, sat quietly in a chair. December 3: three days without bromide. Fears and agitation returned. December 3 to 6, 180 grains a day. Quiet, not agitated. For the next month 90 grains a day. On January 14 she went to work in the stocking shop. Bromide was discontinued from February 9 to 18 when agitation returned, and she quit work. From February 18 to 28, 120 grains a day. Again she became quiet and composed, went back to work, said she felt better, wrote two letters home, these being the first written by her since admission. During the month of March she continued to receive treatment. When treatment was stopped even for three days she promptly became agitated and fearful. But when treatment was resumed she as promptly became quiet. The dose has been gradually reduced so that since April she has been receiving only 30 grains a day. Since treatment was begun she has gained 17 pounds in weight.

WEIGHT CHART.

Nov. 1.....	74 pounds.	Feb. 7.....	86 pounds.
" 8.....	74	" 14.....	86
" 15.....	74	" 21.....	86
" 22.....	74	" 28.....	86
" 29.....	76	Mar. 7.....	87
Dec. 6.....	78	" 14.....	88
" 13.....	82	" 21.....	87
" 20.....	80	" 28.....	88½
" 27.....	81	Apr. 4.....	90
Jan. 3.....	82	" 11.....	89½
" 10.....	84	" 18.....	89
" 17.....	85½	" 25.....	90
" 24.....	85	May 2.....	91
" 31.....	86		

L. G., admitted April 11, 1922, aged 25 years. Diagnosis: Dementia præcox. This patient showed a variable reaction. At times dull, stupid, mute, untidy, spoonfed, sat or lay about the ward all day. Again, excited with explosive outbreaks lasting for several days, screamed, and threw herself on the floor.

Bromide treatment: October 4 to 15, 120 grains a day. Still noisy. From October 15 to 22 she averaged 300 grains a day. Much quieter, fewer outbreaks, smaller doses given, *e. g.*, 120, again 90 grains daily. October 27, stupid, sleepy, toxic, bromide was stopped until November 11. During this time quiet, no noisy spells. November 11, crying, and noisy. Given 150 grains of bromide, she remained quiet for a week. November 21 to December 22, 90 grains a day. "Quiet, composed, comfortable, eats, and sleeps well, no outbreaks."

No bromide was given from December 22 to February 13. She remained in a comfortable condition. February 13, 150 grains. During the month of March six doses were given, and during the month of April, two. The bromide is given only when the patient shows evidence of an impending outbreak.

Weight when treatment was begun was 94 pounds. When discontinued on December 22, it was 96 pounds, a gain of two pounds.

During the next 52 days, when no bromide was given there was a loss of 11 pounds. To date there has been a loss of 10 pounds.

WEIGHT CHART.

Oct. 4.....	94 pounds.	Jan. 24.....	88 pounds.
" 11.....	96 "	" 31.....	87 "
" 17.....	96 "	Feb. 7.....	87 "
" 25.....	97 "	" 14.....	84 "
Nov. 1.....	96 "	" 21.....	86 "
" 8.....	94 "	" 28.....	89 "
" 15.....	95 "	Mar. 7.....	87 "
" 22.....	94 "	" 14.....	88 "
" 29.....	95 "	" 21.....	89 "
Dec. 6.....	96 "	" 28.....	86 "
" 13.....	95 "	Apr. 4.....	88 "
" 20.....	95 "	" 11.....	86 "
" 27.....	96 "	" 18.....	82 "
Jan. 3.....	92 "	" 25.....	81 "
" 10.....	91 "	May 2.....	84 "
" 17.....	92 "		

The next case is given to show the effect of treatment on a dull inactive patient. E. S., admitted June 23, 1923, aged 22 years, diagnosis: Dementia præcox. Dull, stupid, apathetic, stubborn, resistive, had to be taken to dining room and forced to eat, sat with hands over face, seldom replied to questions, untidy in appearance, unemployed. Content: "A man comes into my room every night. He murders me every night. He stuck a knife in my heart." Bromide treatment was begun September 22, 1924. For four days she received an average of 300 grains a day when she brightened up, wrote a letter to her brother for the first time in several months, and said she felt better. October 1 to 14, 180 grains a day; active, neat, tidy, worked in the occupational therapy class. She ate well. "One of the first to the dining room." From October 14 to November 10 she received an average of 240 grains a day. She remained active, talkative, continued to work in occupational therapy class. From November 10 to December 1 there was a gradual reduction of bromide to 90 grains a day. She did well, worked, was active; delusional ideas unchanged. December 1 to 16, 90 grains a day. She was voluble, active, worked, gained in weight. No bromide was given from December 16 to March. About March 4 she became dull, stupid,

untidy in appearance, sat about half dressed. She was more delusional than formerly.

On March 4, 5, 6, and 7, she received 210 grains a day. She showed immediate improvement. She became active, and neat in appearance, and so remained for five weeks when she again became dull, and inactive. Treatment was resumed, improvement was prompt. She became active, and more interested in her surroundings. She helps with the ward work. She several times has tried to run away from the occupational therapy class, hence she is now kept on the ward.

Since treatment was begun she has gained 17 pounds in weight.

WEIGHT CHART.

Sept. 20.....	107 pounds.	Jan. 17.....	124 pounds.
Oct. 4.....	114 "	" 24.....	122 "
" 11.....	117 "	" 31.....	122 "
" 18.....	121 "	Feb. 7.....	121 "
" 25.....	124 "	" 14.....	121 "
Nov. 1.....	124 "	" 21.....	119 "
" 8.....	122 "	" 28.....	119 "
" 15.....	122 "	Mar. 7.....	119 "
" 22.....	124 "	" 14.....	119 "
" 29.....	125 "	" 21.....	119 "
Dec. 6.....	125 "	" 28.....	123 "
" 13.....	123 "	Apr. 4.....	124 "
" 20.....	122 "	" 11.....	124 "
" 27.....	121 "	" 18.....	128 "
Jan. 3.....	122 "	" 25.....	125 "
" 10.....	123 "	May 2.....	124 "

I now wish further to illustrate the effect of the drug on conduct disorders. The cases selected were those most difficult to care for because of frequent outbreaks of violence or destructiveness or both.

E. L., admitted in December, 1916, aged 25 years. Diagnosis: Dementia præcox. For about four years she was kept in a room and much of the time she was kept in bed. When allowed in the day-room she made impulsive assaults on other patients and employees. She was regarded as dangerous from the fact that she so often attempted to bite people, especially on their ears. In three instances she succeeded, each patient losing part of an ear. Treatment was begun on September 24, 1924. She gradually improved. On November 5 she helped make beds, and she ran a floor brush. Since that date she has received treatment whenever she has shown a tendency to become irritable. As a result she has become industrious, and helps with the ward work. She has made no assaults for several months past.

F. C., admitted September 18, 1921, aged 23 years. Diagnosis: Dementia præcox. She is of the athletic type of build, and exceedingly strong physically. She has been disturbed for about two years. About twice a week she would become exceedingly violent. Then she would throw chairs and other articles of furniture at the nurses. Her violence was so marked that the nurses were in terror especially at night. About ten times a day it was necessary to put her in a room to prevent outbreaks. She tore her bedding in pieces, wet, and soiled her room. She was not allowed to have a bed as she would take it apart, and pound the door and walls with it. She had to be dressed, and undressed.

Treatment was begun on October 16, 1924. She received at first 210 grains. From October 17 to 19, she received 300 grains a day; from October 20 to 23, 180 grains a day. On October 24, 30 grains. She became quiet, clean about her room, dressed, and undressed herself. She begged for a bed saying: "I'll be good; I won't do it any more." Treatment was discontinued for four days, then symptoms returned, and bromide was again administered. In the past two months bromide has been given quite regularly. During that time on four occasions she has shown quite marked outbreaks of excitement, the rest of the time she has been rather easily cared for.

M. M., admitted March 24, 1921, aged 25 years. Diagnosis: Dementia præcox. Athletic type of build. She was exceedingly hostile to all of the employees and to some of the other patients because of her delusional ideas. She took advantage of every opportunity to make assaults or to undo what had been done on the ward, and she could not be reasoned with or interested, although much attention was given her on the part of the physicians.

Treatment was begun on August 21, 1924, and was continued with interruptions until November 4, when she began to show marked toxic symptoms. While not stupid she was very ataxic. There was marked loss in weight. Treatment was at once discontinued. She is now in excellent physical condition weighing more than she weighed when treatment was begun, and she is in a much better mental state. She rarely now makes an assault, and she is much more agreeable, and less delusional than formerly. At bed-time, though, she is often somewhat negativistic, especially when told to undress. No bromide has been given since November 4.

A. H., admitted March 3, 1923, aged 43 years. Diagnosis: Dementia præcox. The patient was entirely controlled by hallucinations and delusions. She thought she was surrounded by men who were using her for immoral purposes. She would not wear dresses sent by husband. She destroyed her clothing, and would not keep anything on except her dress, and this she slit up the sides, "to make it more convenient for men." She talked to voices constantly, using vile language. She could not be taken to the dining room because she exposed herself. She had to be dressed, and undressed. She was unemployed.

Treatment was begun September 27, 1924. She received from 120 to 300 grains a day, without obvious change in conduct for over a month;

then she began to take more interest in her appearance. She put on dresses sent by her husband, and reacted less to hallucinations. During January she gradually became quiet. Treatment was discontinued on January 31, and she was sent to a quiet ward. She did crochet work and read newspapers. Again becoming disturbed she was sent to a disturbed ward on March 15, and treatment was renewed. She does not curse and swear any more, and she works well on the ward.

J. R. (colored), aged 51 years, duration of psychosis, 27 years. Diagnosis: Dementia præcox. She is of the athletic type of build. She was given to outbreaks of violence. Several times a day she assaulted other patients. Often she threatened to kill attendants and nurses. She was usually unemployed for the reason that anything she attempted to do was likely to end in a fight.

Treatment was begun on October 10, 1924. For six days she was given from 120 to 240 grains of bromide daily. Then she became "drunk" like an alcoholic. She was happy and smiling, with thick speech, and ataxic gait. When asked what made her drunk, she replied: "Some of that white wine they gave me." The next day she was found washing the woodwork vigorously, and at the same time talking religion to another patient. Since that date she has received bromide whenever she begins to show irritability. The result is that she is usually good natured, and works well on the ward.

The next case is of interest from the fact she had regressed so far that she was quite out of contact with her environment, hence was most difficult to care for. B. C., aged 35 years, has been at the Utica State Hospital for ten and a half years. Diagnosis: Dementia præcox. Anterior poliomyelitis at 14 years with resultant impairment of function of both legs. For over three months before admission she had been extremely noisy, shouting, screaming, and using most vile, obscene language. She tore her clothing into ribbons, and the only way she could be cared for was to place her between two strong blankets without nightgown. She wet and soiled constantly.

Treatment was begun on November 11, 1924, and for one week she received 120 grains of bromide in the morning, and 60 in the afternoon. The bromide was then discontinued for the reason that the patient had become very neat, pleasant, tidy, and not destructive. She went regularly to the toilet. She regressed to her former state, and 150 grains, daily, were given from January 13 to February 1, when the dose was cut to 90 grains. On February 15 the drug was again discontinued for the reason that she was very neat, pleasant, tidy, and went regularly to the toilet. Since that date she had an occasional outbreak of excitement but she promptly becomes quiet, neat, and agreeable when treatment is renewed. At the present time she is neatly dressed, and is kept in the day room.

Another patient, R. G., showed a similar reaction. She was admitted May 2, 1916, aged 39 years. Diagnosis: Dementia præcox. She was unemployed, noisy and untidy, wetting and soiling. She quite regularly stuffed bedding into the hoppers. Treatment was begun September 9, 1924, and was discontinued on November 13. Since that time she has not stopped up

the toilets, and she does not longer wet or soil. She runs a polisher and helps with ward work. She has remained pleasant, and agreeable and further treatment has not been necessary.

In the next two cases the erotic and autoerotic tendencies were the outstanding features. Both have improved under treatment.

C. M., admitted March 2, 1922, aged 38 years, single. Diagnosis: Dementia præcox. She was exceedingly restless and agitated, untidy and destructive, tearing her clothing in pieces. She masturbated constantly, and openly. She had a mask-like expression.

Treatment was begun on August 20, 1924. Within a week she became quieter. She spoke of her inability to control herself, and asked that the medicine be given her regularly. Later when the drug was discontinued there was in each instance a prompt return of conduct disorder. The drug was then given regularly for a number of months. Lately she has shown much interest in her personal appearance. She is much neater than formerly. She has not been known to masturbate for five months past, and there is no agitation.

M. M., admitted February 17, 1924, aged 26 years, married. Diagnosis: Dementia præcox. Early in the attack there were complaints of sexual assaults. Beginning in January, 1925, there was a gradually increasing eroticism. She at first invited the physicians to get into bed with her. Next she tried to drag them into her bed. Finally she made sexual advances to every man that came on the ward.

Treatment was begun on April 10. Beginning with 120 grains, daily, the dosage was gradually increased until on the 19th of April she was receiving 300 grains daily. While erotic towards men she stopped masturbating about April 20. Since the first of May she has ceased to annoy the physicians and other men who pass through the ward.

In order more accurately to determine the effect of bromide on patients at the vegetative level who show disorders of conduct, such as wetting, and soiling the bed, floor and clothing, and destroying bedding, clothing, and other articles, charts were made, and records kept both day and night of the number of times untidy, and of the number of articles destroyed by a group consisting of four deteriorated females, dementia præcox patients, for a period of twenty days before treatment was begun.

These patients were then put under treatment for three successive periods of twenty days each and records kept as before.

The results of this investigation may be summarized as follows: The total number of antisocial acts of the combined groups for the control period of 20 days was 170. Wetting was the most frequent disorder, occurring 116 times. Of this number wetting

of the floor occurred 60 times, of the bed 26 times, and of clothing 30 times. Soiling was next in order with a total of 41. Of this number soiling of the floor occurred 28 times, and of the bed 13 times. Twelve of the 13 articles destroyed consisted of bedding. The other was an article of dress.

The total for the sixty-day period (three times the length of the control period), when the patients were under treatment, was 196. Of this number wetting occurred 153 times, soiling 35 times, and destroying eight times. Wetting of the floor occurred 82 times, of the bed 18 times, and of clothing 53 times. Soiling of the floor occurred 14 times, of the bed eight times, and of the clothing 13 times. Five articles of bedding were destroyed, two articles of dress, and one article of furniture. Comparing the periods mentioned it is seen that there was a reduction of 61 per cent in the number of acts representing disorders of conduct in the patients treated.

For the purpose of determining more definitely the accuracy of these results the treatment was continued, and about two months after the close of the 60-day period, observations were made as before for a period of 11 days. During that time only two of the four cases treated showed any untidiness, and no destructiveness. One wet her clothing on three different occasions; the other wet, and soiled her clothing once and wet her bed once, a total of six for the 11-day period or 12 for the 20-day period as against a total of 170 for the 20-day period prior to treatment. This represents a final reduction in untidiness and destructiveness of 93 per cent.

In order to determine the effect of the drug on the body weight, the weight of the patient was taken before treatment was begun and again when the patient was well under the influence of the drug. Observations were made on 56 patients. Of this number 22 or 39 per cent lost weight, 12 or 21 per cent showed no change in weight, and 22 or 39 per cent gained in weight. Of the 22 who lost in weight, the loss was under 5 pounds in 7 cases, from 5 to 10 pounds in 8 cases, from 10 to 20 pounds in 4 cases, and from 20 to 30 pounds in 3 cases. Of those who gained in weight, the gain was under 5 pounds in 8 cases, from 5 to 10 pounds in 8 cases, from 10 to 20 pounds in 4 cases, and from 20 to 30 pounds in 2 cases.

The effect of the drug in these two groups, it is seen, is directly opposite. The fall in weight in most instances is apparently due

to the production of a toxic state. When there is gain in weight the drug seems to act as a tonic. The patient becomes more active, and has a better appetite. The latter is quite a different picture from that seen following the continuous administration of smaller doses over long periods of time. With the smaller doses, there is almost invariably produced a toxic state, loss of weight, skin rashes, etc. With the larger doses, with the exception of a transient erythema, rashes are rather infrequent. Again, while the smaller doses seem to dull the intellect, the larger doses not infrequently produce a more active mental state. In the third group representing 21 per cent of the cases, there were no changes in weight, hence it is found that in 60 per cent of the cases the weight is either unaffected or there is gain in weight.

To determine the effect of the drug on bodily functions observations were made on eight patients. Six of the cases showed a slight reduction in hemoglobin, two showed a slight increase. The red cells, however, showed an increase in five and a decrease in three cases. The test for renal function on two cases was not altogether reliable. The patient would not co-operate for the test. The blood chemistry showed a reduction in creatin, urea and urea nitrogen. But more work needs to be done before any very definite conclusions can be drawn. The blood pressure is lowered from 10 to 20 millimeters as a rule.

Lumbar puncture done on three patients during the course of the treatment gave negative results.

The total number of patients treated was 85. Of this number 82 were women, three were men.

The terms used to describe the mental condition of patients following treatment are: Recovered, much improved, improved, slightly improved, and unimproved: By much improved is meant that the patient has made a nearly complete readjustment and is able to leave the hospital. By improved is meant that decided changes have taken place in the behavior of the patient, which can be definitely ascribed to the treatment. If by occasional courses of bromide the patient can be held at this higher level he is still classified as improved. Slightly improved means that the patient is less of a problem than before treatment was begun and that the degree of improvement is such as can be readily recognized. Of the group treated four were regarded as having recovered, two as

being much improved, 37 (35 women, two men) as improved, 21 as slightly improved and 21 (20 women, one man) as unimproved. It is seen, therefore, that while 50 per cent of the cases showed a decided improvement, 75 per cent benefited to some extent at least by the treatment.

The influence of bromides appears to me to be explainable by reference to its known influence as a sedative or quieting agent in the domain of the autonomic system. The older generation of physicians esteemed it as the best agent for relieving erotic tension. How far its usefulness in so-called "nervous" conditions (functional) depends upon this particular effect did not suggest itself to them.

As it is a reliable remedy when exhibited for the control of normal adult erotism it can be seen that it would be effective in cases where the manifestations of erotism are perverse.

In the psychotic, by reason of regression, the erotic tension manifests itself at inferior or infantile levels, often the polymorphus perverse, and the individual concerns himself with oral, anal, excretory, and sadistic impulses. When the tension is freed, the libido is at liberty to occupy itself with more socialized interests.

The results obtained in the treatment of functional psychoses by the use of sodium bromide may be summarized as follows:

Patients showing marked habit deterioration such as soiling, wetting, and destructiveness, become more cleanly, less destructive and better able to care for themselves; and patients given to outbreaks of violence, with a tendency to assault, become much better adjusted to their environment, and their activities are more easily directed into useful channels, following treatment.

Agitated, depressed states show much less agitation and take food more willingly; some gain in weight providing that a toxic state can be avoided; some recover. There have been no suicidal attempts by patients receiving treatment.

Patients requiring tube feeding will, as a rule, take food voluntarily after bromide has been given in the feedings for two or three days.

Some patients showing marked regression have their attacks terminated by the treatment.

Patients, showing manic phases in which destructiveness and untidiness, such as wetting and soiling, are prominent features, are

improved in habits but without otherwise influencing the manic picture to any great extent.

Autoeroticism usually resists rather stubbornly for a time but finally responds to treatment.

The conditions which respond best to treatment are usually those in which some degree of tension is shown, indicating that the fight has not yet been entirely given up.

The more lasting improvements are found, naturally, in those cases previously regarded as having a favorable prognosis. Most of the failures have occurred in states of apathy.

Thus far only the benefits to the patients treated have been discussed, but when one considers the changes in the environment of the patients not treated, shown by lessened disorder, confusion and untidiness, together with the conservation of energy of the nurses and other employees, which can consequently be directed into productive fields of activity, the results are of still greater value.

To state the problem from the standpoint of economy, the cost of the care of the patients is lessened. There is a marked reduction in waste of clothing and bedding from soiling and tearing, and fewer articles have to be repaired and laundered. Besides, fewer nurses are required to care for disturbed patients. In this connection the statements of the nurse in charge of the disturbed ward and of her assistant are significant.

The one said: "Before these patients were treated we had to struggle with them every morning to get them bathed and dressed. Then when one was dressed and put in the day room, her anger having been aroused because of the attention necessarily given her, a fight with another patient usually resulted and the combatants had to be separated before further work could be done. This was a frequent occurrence every morning. By the time the patients were finally bathed and dressed we were all tired out from struggling with them before the real day's work had begun."

The other stated: "Before the treatment was begun it took four or five of us to bathe and dress these patients. Yesterday morning (*i. e.*, some months after treatment was instituted) I supervised the bathing and dressing of these patients alone."

Further it should be said that many of the patients treated become quite good workers, while the more deteriorated and nega-

tivistic ones are made more co-operative, hence are more easily trained at the occupational therapy and the industrial centers. Again the standard of housekeeping on the disturbed wards is materially raised. It is possible to keep the wards cleaner and the patients better clothed as a result of treatment. The effects on their companions of the activities of one or two disturbed patients on a ward are too well known to need further elaboration.

In the administration of this drug in large doses, constant careful observation on the part of both nurses and physicians of each symptom produced by the drug is very necessary in order to prevent the development of distressing symptoms. Not infrequently patients quickly develop stuporous states or other evidences of a toxic condition which require prompt and energetic treatment. For this reason it is necessary to determine as accurately as possible the tolerance to the drug of each case treated. Unless this is done the administration of the drug is not without danger. It is also a dangerous procedure to administer bromide in large doses to a patient who is kept in bed during the treatment. He may develop a stupor which may result in a fatality if the condition is not promptly diagnosed and treated.

It is much better to keep the patient up and dressed and walking about. Then, when the ataxia of gait appears one is informed that it is time to discontinue the drug, temporarily at least. If the ataxia becomes too marked so that the patient is in danger of being injured by a fall he can be put to bed. Briefly to illustrate the difficulties one may encounter, the following example will be cited: A case of recurrent, agitated depression was given 120 grains for three days when she became quiet. The drug was discontinued. Later some agitation became manifest. The patient was then transferred to the ward for depressions, and 60 grains of sodium bromide were given daily for four days. At the end of the fourth day the patient suddenly became so stuporous that she could not be aroused by any form of stimulus and so remained for four days. Had larger doses been given, a fatality might have resulted. Now 15 grains daily for two or three days are sufficient to produce marked drowsiness.

For the relief of toxic symptoms, saline solution by mouth should be freely given to cause prompt elimination of the bromide. Besides, if possible, keep the patient walking. Render support when necessary. The marked constipation which also often re-

sults can be relieved by administering saline cathartics or mineral oil.

Feeble or decrepit patients or patients suffering from organic, lung or kidney disease, or heart disease with low blood pressure, should not be treated by this method.

With some patients the best results are obtained by the administration of large doses (*e. g.*, 210 grains) for a few days followed by periods of interrupted treatment, while with others the best results are obtained by daily doses of smaller quantities of the drug (*e. g.*, 90 grains). There is no rule by which one can be guided in the selection of a method; daily observation of the results obtained is the best guide.

Failures often occur from the fact that when improvement does not take place in a few days, the drug is stopped. Again the return of symptoms is regarded as evidence of failure.

When one regards the drug as an aid to therapy rather than as a panacea, a better appreciation of its value will be had.

Further in regard to treatment I may add that one should not stop with the use of the drug alone but should utilize all other forms of therapy in order that the patient may be kept at the higher level to which the drug, temporarily at least, has brought him.

In conclusion, I wish to emphasize the extension of the general hospital idea to the treatment of the so-called chronic functional types of mental disorder. If this is done, I am sure that greater results than any yet achieved will be obtained.

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DISCUSSION.

DR. R. F. WAFER.—Such a therapeutic discussion comes up so seldom that I should like to continue it, and take this opportunity to endorse Doctor Wright's method of using bromides.

I have found it very efficacious, especially where I did not have the advantages of institutional restraint, such as in a general hospital. In the patient's home and with patients who did not have sufficient means to allow adequate nursing, and also in those instances where the patients had the financial means but were unable to procure nurses competent to handle mental patients, it has been a great aid.

I have used the same method with some deviations with good success, giving from 15 to 30 grains of Sodium Bromide per dose, and added to that 7 to 15 grains of Chloral Hydrate, $\frac{1}{4}$ to $\frac{1}{2}$ grain of Codein and 2 to 5 drops of Tincture of Belladonna in a vehicle such as Aromatic Elixir or Elixir of Lactated Pepsin. This combination is especially valuable in those cases where the patients are agitated, destructive, abusive or otherwise overactive. Many of the manic depressive cases of the manic type, the agitated depressions, the excited general paretics and acute delusional states react well to this form of treatment. In some of the excited manics, I have found it of great assistance to use Tincture of Opium, especially in those cases where nasal feeding was necessary, usually starting with 15 to 20 drops of Tincture of Opium once or twice a day and increase the amount daily until the desired effect is obtained. There is no danger in the patient's acquiring a drug addiction by using Opium in this way during mental excitement.

In acute alcoholism, I have found Paralydehyde especially valuable, using from one dram to one ounce per day, according to the needs, and later substituting the combination of Bromides and Chloral. The Bromides and Chloral are especially efficient in allaying the delirium and the agitation of the patient when withdrawing the alcohol.

In all instances, preference should be given to hydrotherapy instead of drugs, but hydrotherapy is often unavailable or impracticable and the use of drugs is very valuable and almost essential for the successful treatment of the patient.

DR. SPRAGUE.—I am very much interested in Dr. Wright's method of obtaining results with bromides in comparison with some recent work by Fleck in Munich. By the administration of cocain to stuporous cases, he obtained transitory periods of partial accessibility. But while this gave some insight into the hallucinatory and delusional content, he got no permanent effects. In contrast to this brief whipping up of activity I would like to ask Dr. Wright if he explains the improvement he has observed on the basis of cerebral recuperation due to marked decrease of activity following massive doses of the sedative.

DR. WRIGHT (in closing).—The effects of small doses of bromide over long periods of time are too well known and too well described in works on

therapy to need further elaboration. But I tried to make it clear that one sees this type of reaction infrequently following the administration of bromide in large doses. As previously stated, in 60 per cent of our cases the weight was either unaffected or there was gain in weight, while none of those who lost in weight showed symptoms of bromide delirium. Besides, instead of being made dull, patients usually became more active mentally. Replying to Dr. Sprague's question in regard to the action of the drug I will say that when I began this work I thought I knew its action, but at times reactions occur which cause me to wonder whether or not I am altogether correct.

One of the first things I learned in pharmacology (Cushny) about the action of bromide was its effect in relieving erotic tension. In some of the functional psychoses there is abundant evidence of this erotic tension shown in various perverse tendencies and activities. It was, therefore, with the idea of relieving this tension that the drug was so generally given. While some do not agree with this interpretation, it seems, after all, the best explanation that we can offer for the results obtained.



THE NEWER PSYCHIATRY.

ITS FIELD—TRAINING FOR IT.*

By WILLIAM HEALY, M. D.

The modern practicing psychiatrist is called on to be one of the most highly educated and broadly cultivated of all professional people. The field of psychiatry has extended beyond all anticipations of a generation ago—growing from the art of recognizing and treating a dozen or more mental diseases and some psychopathic conditions to its present immensely important and wide outlook upon the causes and possible modifications of human reactive trends as found in mental life and conduct in many manifestations and in many individuals not mentally diseased. A vast new world has been opened to the psychiatrist and, indeed, very largely by him.

Consider, in illustration, some of the problems which in clinics and in private practice crowd upon the modern psychiatrist and demand solution, for somehow he is supposed to qualify as being able partly or entirely to solve them. There are peculiar mental attitudes and behavior manifestations found in family situations, often unfortunate and abnormal even among well meaning and intellectual people; there is a host of school problems being presented, relating both to conduct and to educational progress; there is the work for juvenile courts and for parents who come with delinquents, asking for psychiatric clues to the causes and treatment of conduct disorder; there are the social agencies, particularly those dealing with children, more and more asking psychiatry to step in and help develop a plan of life adjustment, or actually to undertake psychotherapeutic treatment in difficult cases. And less well developed conceptions of the service that psychiatry should render, come, often with specific demand, in connection with industrial relationships, studies of divorce and other social irregularities, teaching the principles of mental hygiene, of good parental relationships and what not.

* Read at the eighty-first annual meeting of The American Psychiatric Association, Richmond, Va., May 12, 13, 14, 15, 1925.

The tendency of the times is very strongly toward discovering a vast deal of imperfect adjustment among human beings that, if the ordinarily intelligent person of today rightly understands what psychiatry is, very properly indeed belongs to the field of psychiatry for better understandings and treatments and adjustments.

To unearth etiology and adequately guide therapy, a wide range of knowledge is requisite—much in art, history, anthropology, the psychology of religion, of adolescence, of family and sex life has to be drawn on. Indeed, concerning these last matters the psychiatrist is called on to have a more profound knowledge than anyone else. Acquaintance with the principles and practice of up-to-date educational, social, recreational, industrial psychology are necessary parts of the psychiatrist's equipment. To be informed concerning the régime and curricula of different school systems, methods of disciplinary control in and out of institutions, devices for combating undesirable habits, is indispensable for intelligent prescription of treatment.

The proper study of the case itself nowadays means a considerable usage of modern psychological science, particularly of mental testings, and at least some pursuit of the analytic method, as well as study of the ordinary symptoms and signs of mental disease.

Already the wider ideas concerning psychiatric practice, quite apart from the technical procedure of psycho-analysis, have received much acceptance among the laity, and notable consideration in literature—philosophical, critical and fictional. Not a little flavor of modern psychiatry is to be found in the writing of Somerset Maugham, Sherwood Anderson, and other gifted authors; specifically and most valuably critical of us is M. P. Follett's *Creative Experience*; philosophers and sociologists during the last decade have made frequent reference to our field.

It is clearly no slight burden to be cultured enough and active-minded enough to acquit oneself acceptably in the rôle of the modern psychiatrist, to make the enormous advance from a meager course of lectures on mental disease offered in the medical school to competent practice of present-day psychiatry. The leaders have gone forward through many years of earnest self-cultivation in a pioneer field. Does such individualistic effort represent the necessary arduous path for oncomers?

We may here ask whether psychiatry is by professional definition to remain so broad in its interests and practice; if it is, then the preparation and education of a psychiatrist are matters about which it behooves us to think most seriously.

The Round Table on Social Psychiatry at the meeting of the American Psychiatric Association last year was devoted to consideration of the definition of the field of psychiatry. To me, as moderator, it seemed to be the unanimous opinion that psychiatry is not an art or a science confined to the study and treatment of mental disease, whether it be psychosis, psychopathy, psycho-neurosis or defect. It was very strongly expressed that it is exactly the psychiatrist's proper business to take over the problems of mental adjustments that are so immediately and overwhelmingly involved in the problems of personality, of family and other social maladjustments, of misconduct, of vocational dissatisfactions, of educational misfittings in primary or secondary school or college. Acknowledging the weight of this program, the burden was felt to be rightfully ours.

Psychologists might long ago have pre-empted large areas of this field, but the academic attitude that almost entirely restrained them has been that psychology must not be concerned too intimately with people's affairs, must never involve itself in such practical matters as therapy. Yet psychology may wake up with a different opinion one of these days, and if the psychiatrist is not well enough trained to handle the tasks he has assumed, it may then be said to him as a doctor of medicine, "Your business is to study and treat the body, the nervous system; we psychologists are best fitted to tackle the purely mental problems." As it stands, psychiatry nowadays is insisting, "It is because of the training of our craft in matters pertaining to the human being as a whole, in his physical, mental and social relationships, that our people should keep control of this field."

In spite of the implications of the recent statement by a great medical man¹ that "the development of the science of psychology is our only hope of improving the quality of the human being," knowing the mind, even its simplest activities, in terms of histology

¹Dr. Alexis Carrel in his address: "The Past and Future Progress of Medicine."

or chemistry of body or of brain cells is a mere dream of the dimmest future. Little indeed of such matters comes into play in the reconstruction of human behavior trends, the reconstructive effort that is of the very essence of the modern conception of psychiatry. This may not be what some of us thought years ago, but we have been forced to this conclusion after years of endeavor to understand through the direct biological approach, an endeavor that has led us to very slight accomplishment in mental therapy. It seems only possible to aim directly at the goal by acquiring all the knowledge we can concerning the structure, functionings and content of *the mind itself*, and utilizing this knowledge as it bears on behavior and conduct.

Psychiatry, holding fast to the primary idea of itself as the science or art of the *treatment* of mental life, must acknowledge, then, that outside of the few troubles where pathological conditions are specifically known to be basic, most fundamental for it is psychology, the science of mental life, though that science must be conceived as involving a much wider range of considerations than are found in academic textbooks on the subject. The material of an older structural psychology, associations, memory, will, perception, attention, plays but a part in the conception of mental life that modern psychiatry holds. The latter embodies a wide view of mental content and of its activities, of urges and drives and instincts, of the vastly important facts that have been brought out by the exponents of what is properly called dynamic psychology, and even of behaviorism. And then there is the psychology of abilities, already emerged from the stage of arithmetical rating by age-levels and intelligence quotients.

A training that encompasses this point of view is imperative for the psychiatrist if psychiatry is going to accept rank as a therapeutic and preventive science, and particularly if it is going to handle successfully the manifold personality and behavior problems of childhood and youth, or, even more specifically, if this profession is going to be capable of understanding and really directing the rich variety of educational and re-educational processes that may be utilized. We who are attempting these tasks have found that our most efficient aids are in retrained parents, in social workers who have the psychiatric point of view, in intelligent foster parents whose homes are utilized for the placing of children, occasionally

in educable employers, and particularly in progressive teachers interested in the individual. In respect to the teaching program itself, one finds it most necessary to be acquainted with, to utilize or to take a hand in the development of special regimes, now for the specially deficient, now for the specially gifted, or for the specially interested child. Sometimes it is the nursery school or kindergarten, or the trade school, the project scheme, the tutorial, the Dalton or the Winnetka procedure that may be of great assistance in mental therapy. And so, altogether, the advice and the direction that are sought so ardently nowadays from the psychiatrist require on his part not only much knowledge of etiological factors in mental life, but also much consideration of the possibilities and technics of mental, social and educational modifications.

Adequate training for the practice of modern psychiatry also includes, however, development of personality characteristics and skill in technic in just the fashion of other professional specialties. Only here, perhaps, is demanded more than anywhere the cultivation of a remarkable combination of a sympathetically subordinated understanding and a commanding personality. It is often a serious and not an easy task to carry through to a good end the mental operations necessary—even our terms, mental exploration, psychic trauma, are indicative of what is involved. Over and beyond what may be learned from books, and what vocabulary, often professional jargon, may have been acquired, quite indispensable for success (and observation of many medical people working with the problems of modern psychiatry has taught me a deep lesson in regard to this) is an achieved ability to put patients, perhaps primarily unwilling patients, through necessary mental operations. Sometimes the adult and frequently the child to be studied can only be successfully approached and dealt with through a personal technic or procedure that is attainable through no little attention to the requirements of such situations and practice in them.

Practically, what is the situation at the present time in this matter of the training of the medical man or woman for service in the field of the newer psychiatry? Most easily, perhaps, we can state the really minimum requirements: 2 years of a good college course, 4 years in medical school, 1 year in a general hospital as obligatory in some states for practice, 1 year in a hospital for mental diseases, 1 year in extra-mural psychiatry. Here are 9 years gone. (And

through 3 years of college and the 5-year curriculum of some medical schools many will find the total to be 11 years.) But we are frankly afraid that even under this plan very little essential psychology is going to be absorbed; that there is not likely to be much of it in the short years of college, with all the need for languages and science as pre-medical requisites, nor in the medical school with its over-crowded curriculum, and certainly not in the grind of hospital work. It seems very doubtful if any fair chance for the absorption of sound psychological knowledge is to be had until the 8th or 9th year, and then only under exceptionally favorable circumstances in regard to the opportunity for study and for receiving instruction while dealing with patients. And in these last years there is so much that it is necessary to gain acquaintance with—special matters in neurohistopathology, serology, radiology, endocrine biochemistry.

Will many undertake more than 9 years of training? And for my part, I think that under the plan of the psychiatrist being educated to be a medical practitioner, 12 years much more nearly represents the real requirements of modern psychiatry. Occasionally someone will go on; I know some such splendid students; and others after entering practice or after service in a hospital for mental disease may be induced to equip themselves through scholarships such as the Rockefeller Foundation is offering through the National Committee for Mental Hygiene. But not nearly enough people are coming forward to fill the demand for well-trained and experienced psychiatrists.

There are nothing like such requirements in any other profession except, some will say, in the other medical specialties. But the situation there is entirely different. Training for any other specialty leads directly out of the work of the regular medical course and from experience in the general hospital. Here acquaintance with another science is required, a science which has no foothold and very little background in the medical curriculum. Psychology represents in its data and terminology a new discipline for the medical student.

Does the path to this fine human service seem too long, and by reason of the length unattractive as compared with other medical work? And if so, can we alter the educational situation? The field has been immensely widened; modern psychiatry should be safe-

guarded to a position of professional permanency. More strong people are needed in it. But the psychiatrist can only retain his hold on his new work through not appearing ridiculous; he dare not take up with the problems offered in connection with educational or social or legal or industrial issues or even as related to personality and family situations unless he is equipped really to understand them and to deal with them. Already one hears ominous rumblings of criticism.

Searching for some way out of the difficulty it may first be asked whether the psychiatrist need be a qualified general medical practitioner. So far as fulfilling the requirements of sound psychiatric practice is concerned, it seems clear that the psychiatrist need not undertake to cover the medical courses or the clinical work or pass state board examinations in several subjects, for example, obstetrics and surgery. Indeed, a lot of work in anatomy, physiology and medicine, and special branches of medicine, could perfectly well be dispensed with if the psychiatrist need not qualify as a general practitioner. And why should he practice any of several departments of medicine, any more than the ophthalmologist does obstetrics, or the neurologist undertakes abdominal surgery?

Perhaps the psychiatrist might have a special degree—his field and service are big enough to warrant it and to warrant a special examination and certificate of registration. Or if the usual medical degree is retained, there might be a special required course and a special examination. Psychiatrists might be trusted not to undertake medical work for which they are not qualified, equally, for example, with ophthalmologists.

The dilemma is evident from what already has been said. No plea is being made for a less severe discipline, rather for a severer training. Here is a department of knowledge, a field which the medical profession proposes to control, and which, if well-steered, is bound to become exceedingly influential in the service of mankind. To produce the right sort of education for this modern psychiatry, to catch the right sort of students for it—these are tasks of the present.

It would seem easily possible to drop two years or more from a standard medical course and general hospital service and to fill this time before graduation or before state board examinations with definite psychological training and medico-psychological service.

The necessary changes in requirements for medical school graduation and for state registration should be far from insurmountable. What other way is there to give the right sort of training and get the best students?

Anyhow, a ringing challenge has come to the psychiatric profession to attract the most capable young men and women to the practice of what should and readily may grow to be considered the most dignified of all professions—that which is concerned with and treats mental life, the innermost and real being of man.

DISCUSSION.

DR. HAVILAND.—As a member of the Executive Committee of the National Committee for Mental Hygiene, I have been impressed with the lack of sufficient properly qualified personnel to fill the many psychiatric positions for which candidates are sought, both in institutional and extra-mural work. Through the aid of the Commonwealth Fund, a number of scholarships for both psychiatrists and psychiatric social workers have been established by the National Committee for Mental Hygiene. However, the need is so great for qualified psychiatric personnel that such relatively few scholarships will afford little relief.

Dr. Healy has clearly indicated the serious situation which exists. If psychiatry is to render the service it should, increased personnel is imperative. The pioneer work done by Dr. Healy and the results he has obtained in the field of juvenile delinquency have been of tremendous importance in impressing the public mind with the possibilities of psychiatric work among problem children. There can no longer be any doubt that the most effective prophylaxis in mental disease is to be obtained through psychiatric work with children.

In the State of New York plans have been formulated to initiate such work on a state wide, systematic basis through the joint efforts of the State Hospital Department and the State Educational Department. An attempt is being made to interest the 1400 school physicians of the state in the matter in the hope they may refer problem children in the grade schools to the 44 mental clinics maintained by the state hospitals, provision having been made for increasing clinic personnel to carry the additional work. However, it is realized that the work must develop gradually if it is to be well done. Emphasis will be placed upon quality rather than quantity, as it is appreciated that intensive work with concrete results will alone enlist permanent public support.

The interest of the general medical profession is also essential if progress is to continue in social psychiatry and in mental hygiene activities. But such interest is being awakened. A sign of the times is a special session devoted to the consideration of mental hygiene and mental disease which

is being held this week as a part of the program of the annual meeting of the New York State Medical Society in Syracuse.

The lack of interest in psychiatric matters heretofore evident among general practitioners has been the natural result of their unfamiliarity with modern psychiatry and its therapeutic possibilities. As medical colleges are now providing better courses in psychiatry, the physicians of the future will be better able to appreciate the rôle psychiatry should play in general medicine, and the necessity of dealing with social problems from the psychiatric viewpoint.

An important agency in providing facilities for both undergraduate and post-graduate work in psychiatry will be the New York State Psychiatric Institute and Hospital which is to be erected in connection with the Columbia University-Presbyterian Hospital Medical Center in New York City. Although a state institution erected upon land deeded to the state, it will be in intimate physical association with the general medical center in which all major medical specialties will be represented. Such an association cannot fail to be of enormous reciprocal advantage in the field of therapy, but the educational opportunities rendered available by the new institution should result not only in increased knowledge of psychiatric work and method among the general medical profession, but should be of great assistance in developing young medical men for the under-manned psychiatric field. By offering the best in psychiatric instruction, the best men will be attracted. Lack of adequate personnel will be overcome when psychiatric possibilities are made evident to medical students and ready means are available for the study and scientific investigation of what is the most alluring of all branches of medicine.

DR. WHITE.—I would like to add a word to what Dr. Haviland has said and call the attention of the association to the fact that there is already a program in another branch of medicine which is approaching the same problem from another angle. I refer to the schools of public health which have been established in connection with several universities, and the suggestion has come to us through the National Committee of Mental Hygiene that one of the solutions of the present difficulty might easily be the establishment of separate educational courses in neuropsychiatry with a separate degree in neuropsychiatry. I wanted to be sure that the association knew of this suggestion so that they might deal with it in the discussion.

DR. ABBOT.—The problem reaches pretty far back. Most general physicians do not yet realize that there is a mental factor in every patient. Consequently the organizers of medical curricula do not realize the necessity for psychology as part of the medical curriculum. It is therefore up to the psychiatrists, and to others who do realize this necessity, to get over to the general practitioner, as Dr. Bliss has done in Missouri, the importance of the mental factor in his patients. It has long seemed to me that psychology was just as much a basic science for the medical man as physiology,

anatomy, or biological chemistry. But it needs to be taught, not from the point of view of the pure scientist, but from that of the more modern psychiatrist of whom Dr. Healy spoke. It should be adapted and applicable to the needs of the medical student and the practitioner. Often the mental factor is just as important as many of the physical factors in the medical case. Until that general idea becomes fairly prevalent we shall not get very far in interesting medical students or physicians in psychiatry. The time to interest the young man in the mental factors of disease and in psychiatry is while he is still a medical student; it can only be done when the general physician and the teachers in the medical schools realize that these mental factors are as important to them as to us mental specialists. When that is accomplished Dr. Healy's problem will be in the way of being effectively solved.

DR. NELSON.—Indeed we should all be very much indebted to Dr. Healy for presenting this paper. It is of such very great value that we must not forget that we are psychiatrists, primarily skilled in treatment. Dr. Abbot has emphasized the necessity of studying the individual, of regarding psychology as a major subject, but I believe the training toward psychiatry should be much more fundamental. If we are going to get anywhere, this preparation and this training should be done in early life, even back before the students go to college, because it requires a certain mental attitude and certain preparation. Until the psychiatrists who are interested in this question become active and effect a reorganization of the whole educational problem we will not get very far. Preparation for this must become our work from now on. Dr. Healy has pointed out to us that the training for psychiatry carries us back to many branches of learning not taught in medical schools, so that preparation must begin away back. Psychiatrists could do a great deal in this connection and I believe it is within the powers of the members of this association to guide the schools and colleges toward a preparation for psychiatrists as the demand is for them to-day. The teaching of medicine would begin after the individual has finished his college course.

DR. OLIVER.—Mr. President and gentlemen, I only want to add a word to what Dr. Healy said about the difficulties of the modern psychiatrist. I don't like to mention personal matters but the medical service in connection with the courts of Baltimore with which I have been connected for the last eight years is a good example. We started eight years ago and developments were slow. Psychiatrists in charge of that service are expected to solve questions connected with the two Juvenile Courts and we have problems of every kind submitted to us. One difficulty in the training of psychiatrists is that those men there see only cases that are brought before them in the clinic. They have very little opportunity to get in touch with the wide field of neuropsychiatry. Frequently they miss things that those of us who are hospital physicians might notice. On the other hand, all of them have had a patient sent to them as an ordinary depressed

case who, after examination of eye-grounds, was found to be a case of brain tumor. We do not feel that we can skim the cream in the medical training of our men. On the other hand the court physician is in touch with the social service and legal matters and he really gets practically no training for that type of work in most all our medical schools that I know. What the president said in connection with the schools of public health deserves thought and Dr. Welch has realized the necessity of some psychiatric training even for those men who are taking up questions of public health. For three or four years I have lectured in the regular classes in this School of Public Health. Then one other thing which perhaps is encouraging is this: In connection with Dr. Barker's group in Baltimore to which it has become our practice now to send practically every case before it comes in court. Practically every case comes to Dr. Barker's attention except cases that are perfectly clear cut physically. Others are sent to the consulting psychiatrist and the consulting psychiatrist sends in a long and complicated report of that person's personality make-up and the sources of his difficult adjustment. So that even in group medicine and in ordinary medicine it is recognized more and more as a necessity that the personality of the ordinary case be understood. And I think these facts, together with what I mentioned about the School of Public Health, are a decided comfort in our outlook to the future.



PSYCHIATRIC DEPARTMENTS IN GENERAL HOSPITALS.*

By GEORGE K. PRATT, M.D.,
National Committee for Mental Hygiene.

Concerning the need for psychiatric departments in general hospitals much has been written. Even a brief search of the literature on the subject discloses an already extensive bibliography, and it might well seem as though little remained to be said. It is significant, however, that despite the frequency with which this topic has been discussed, many new general hospitals are today under actual or contemplated construction without provision being made in their plans for such departments. The need for further educational work, especially among boards of trustees, municipal hospital commissions and similar governing bodies therefore appears obvious and offers the chief justification for this added contribution to an already weighty literature.

It would be difficult to find an up-to-date general hospital indifferent to the needs of the physically sick in the community which it serves. Even the humblest of rural institutions with its relatively few beds is apt to point with pride to its modern equipment and to the flexibility of its service which permits it to care for a wide range of physical disorders.

But few indeed are the general hospitals, whether metropolitan or rural, that provide at all, to say nothing of adequately, for one important class of patients—the sufferers from nervous and mental illness.

It should be made clear that in the sense the expression is here used, “nervous and mental illness” distinctly does *not* connote “insanity.” Were the problem of mental ill health merely one of “insanity,” the general hospital could not be expected to concern itself with this malady. But today no well-informed person believes the problem of mental ill health to be one merely of “insanity.”

* Read at the eighty-first annual meeting of The American Psychiatric Association, Richmond, Va., May 12, 13, 14, 15, 1925.

Instead the realization is steadily growing that insanity, so-called, is but a later stage in a psychopathologic process, and that the larger number of those who are mentally ill and in need of expert medical attention are not "insane." A goodly number of these persons suffer from types of mental or nervous disability that may be expected shortly to recover, provided appropriate treatment is rendered with promptness and efficiency. Failing these two conditions chronicity and extended institutional care are the usual aftermaths.

It is among these men and women—the acute, incipient and curable cases of mental illness, that the psychiatric department of a general hospital may be expected to exert its fullest usefulness. Already, it seems safe to say, every general hospital unwittingly harbors several "mental" patients in its wards. The fact that mental symptoms were not prominently outstanding at the time of the patient's admission, or else were over-shadowed by his physical symptoms, fails to alter the fundamental nature of his illness. Moreover it often happens that mental symptoms do not manifest themselves until well along in the course of an illness that began essentially as a physical process and solely for which the patient was admitted to the hospital. But while undoubtedly a certain number of such patients are at any given time to be found in the general hospital, a far greater number remain in the community with scant opportunity under present arrangements to receive the special treatment their disorders require. This group suffers from disabilities that do not need state institutional care nor the legal commitment that is a preliminary to such care. Instead they are borderline cases who contribute to the problem of mental ill health by failing to make wholesome adjustments in their social, business or domestic relations. They are handicapped by pathologic mental difficulties that interfere with their success in life and that are expressed in terms of peculiar or anti-social behavior; in so-called nervous breakdowns; in disagreeable traits of personality, or perhaps in some of the psychoneurotic manifestations. But while treatment in an institution for the insane is seldom indicated for these persons, experience abundantly has shown that a relatively brief period of therapeutic attention in the psychiatric department of a general hospital often restores them to health and efficiency.

One of the most important single services a psychiatric department can render to the other divisions of a general hospital is its

assistance with the differential diagnosis and therapeusis of those patients whose physical illness is inter-related with some form of mental abnormality. Among such patients in the medical or surgical wards of general hospitals may be found those suffering from encephalitis lethargica, from poliomyelitis, from various of the meningitides, from toxemias due to renal or other organic malfunctioning, from cerebral tumors and neoplasms, and from many other allied conditions. Then too there are patients in the throes of the deliria of typhoid or pneumonia, as well as those whose post-operative convalescence is interrupted by the onset of excitement, depression or perhaps by strong delusional trends that may or may not be accompanied by hallucinosis. In many of these inter-related conditions the time factor is an urgent one and the degree of accessibility to the consulting services and the special equipment of a psychiatric department (if one exists) may literally determine the question of life or death for the patient.

Mention should not be neglected of still another group of patients found in significant numbers on the wards of general hospitals; a group whose real difficulties all too often are overlooked by physicians who lack psychiatric training. Reference is made to the psychoneurotic; that host of men and women who habitually complain of a wide variety of physical symptoms, few of which permit of pathologic location. They represent a portion of the community's residue of "chronic nervous invalids" who have succeeded in translating their mental conflicts, their worries, their anxieties or their doubts and fears into terms of physical ill health. Many of them are admitted to the hospital by the baffled family physician whose patience and insight into their real and underlying difficulties are alike exhausted. Among them are examples of weird contractures, paralyses, aphonias, blindness, deafness, and other hysterical phenomena. There are also the sufferers from traumatic and industrial neuroses to be considered; the cases of cardiac or gastric neuroses, and the not too occasional possessors of "phantom" tumors. This psychoneurotic group, rich in interest of a fascinating psychopathological nature might alone justify the addition of a psychiatric department to the activities of almost any general hospital. At any rate patients in the psychoneurotic category invariably create a special and a vexatious problem when their care is attempted in the usual wards of

such a hospital. They are notoriously captious, and often resistive to efforts to remove the basic cause of their disability which has usually served them faithfully as an excuse for avoiding most of the unpleasant responsibilities of reality. Many of them when in the hospital are over-sensitive, quick to make accusations of neglect or inattention and invariably are critical of attempts to promote their welfare, or to expedite their recovery. In an open ward they become a serious problem in that they impair the morale of other patients and require a disproportionate amount of service.

Thus it is that a properly equipped and administered psychiatric department will not only enable the general hospital to offer better facilities to those of its patients whose illness is complicated by "mental" factors, but such an addition to its functions permits the general institution at once to become of service to a large group of sick persons in the community who have heretofore been denied hospital attention.

No really insurmountable obstacles will ordinarily be encountered by the general hospital that desires to extend its activities in this way. Only a relatively few beds are needed for such a special department. Five per cent to a maximum of 10 per cent of the total hospital bed space will be found to offer a unit of convenient size for an innovation of this kind. Preferably these should be so divided as to permit of separate divisions, male and female, and should be arranged to offer the maximum number of one-bed rooms as opposed to large wards. What wards are used should probably not be of more than four-bed capacity. If a psychiatric department is determined on at the time new construction is contemplated it will not be difficult to specify special sound-proof walls, a properly designed and adjacent hydrotherapy department, as well as numerous other details of architecture and equipment necessary for the successful carrying-out of the rather unusual service a psychiatric department must render. To assist hospital managing boards and similar groups who may be considering the establishment of such a department, the Division of Hospital Service of the National Committee for Mental Hygiene in New York collects up-to-date architectural and floor plans and administrative details in addition to maintaining an active consulting service. All of these are available on request and without charge to interested persons.

It is unlikely that the administrative problems of a psychiatric department will prove any more vexatious than is the case with most other institutional special departments. It is essential, of course, that the chief of the psychiatric service be a thoroughly experienced psychiatrist. He should be a recognized member of the hospital staff and his authority should not be less than that of other members of that body. He should be familiar, not alone with serious cases of mental disease of organic and chronic types, but also with the varieties of functional mental disorder whose roots so often are inter-twined with personal situations of environment or of unhealthy social, domestic or industrial relationships. Possessed of this breadth of view in searching out and evaluating the causative factors in his patient's disability, the psychiatrist will be as ready to assign weight and significance to the manner and degree of the individual's adjustment to the social fabric of the community as he will to the more mechanistic rôles played by anatomic, neurologic or physiologic pathology.

Nursing problems of a special sort will also arise in the organization of a psychiatric department. But many of these can be minimized by the selection of a nursing supervisor who has had mental hospital training, preferably in one of the larger psychopathic hospitals. She should be permitted to select her assistants from those who likewise have had some acquaintanceship with caring for the mentally sick. Under the aegis of this supervisor and her trained assistants, student nurses from the general hospital may be assigned to the psychiatric department for mental training in lieu of being sent for a similar experience period to a state hospital for the insane. This feature is uniquely valuable because the types of mental disorders seen in the psychiatric department of a general hospital will more closely approximate those cases the nurse will be called on to help in the community than would be the case in a state hospital where chronic and end-result types predominate.

As an adjunct to the psychiatric department established as an integral part of a general hospital it probably will be desirable to organize an active psychiatric out-patient clinic. This also should be under the supervision of the chief of the psychiatric service, although trained assistants may be utilized to carry on the actual clinical work. To such a clinic may be expected to come men, women and children, although perhaps chiefly the latter, who are

not in need of hospitalization but who do require sound psychiatric advice. With the assistance of an adequate number of specially trained psychiatric social workers the doctor in such a clinic will be able to re-adjust and keep at work many patients who otherwise might well drift to the point of needing prolonged hospital care. It is important to stress here the necessity for securing for such positions none but social workers who are graduates of recognized schools of social work where the psychiatric aspects of their duties are thoroughly instilled. The usual medical social worker without special psychiatric training will not be equipped to recognize or to evaluate certain symptoms that otherwise are apt to be neglected or dismissed as inconsequential.

It does not seem presumptuous to predict that the addition to the facilities of a general hospital of a properly organized and equipped psychiatric department will quickly prove the inherent worth of the new service. In the friendly rivalries between other specialities of medicine; in the stimulating debates among proponents of various therapeutic techniques, (already is there indication that psychiatry may prove to be the *liaison* agent; the integrator that unifies, clarifies and resolves all available medical knowledge concerning that human being who is the patient, into one great force of healing power. Certain it is, at any rate, that psychiatry in a single decade has made powerful inroads on former medical concepts of the patient; paralyzing concepts that were prone to think of the sufferer as an impersonal sort of "case," constructed of two isolated and separable units—a body and a mind. And equally certain is it that in substituting for this unscientific view a concept that regards the sick man as possessed of feelings, emotions, and prejudices just as much as of liver, heart or spleen, psychiatry has made it possible for the men of modern medicine to understand their patients as *whole* human beings.

There is no agency in a more strategic position to further the acceptance of such a concept and its resulting goal than the psychiatric department of a general hospital. But until those who control the policies and destinies of general hospitals become more familiar with the advantages to be derived from such a complement to their present functions, and until the psychiatrist shall become as familiar a figure on the wards of

the general hospital as the surgeon and the internist, medical science cannot hope to discharge its fullest duty to those who are commended to its care.

DISCUSSION.

DR. GROVES B. SMITH.—We are indebted to Dr. Pratt for his most excellent presentation of a new but important phase of neuropsychiatry. The establishment of a neuropsychiatric service in general hospitals has passed the experimental stage.

At the Henry Ford Hospital we have found it necessary to divide the service into In-Patient and Out-Patient groups. The In-Patient group averages between forty to sixty patients daily. The Out-Patient group consists chiefly of former In-Patient cases who are being followed after their discharge from the hospital. We average between thirty and forty visits per day, and at this time there is a total of about two thousand cases who are upon our rolls, some being seen once or twice a week, others once in six months, depending upon the nature of the mal-adjustment present.

From an administrative stand-point, fear is often expressed as to the reception of such a service in a general hospital. In this hospital, at the start, cases were indiscriminately placed upon the various floors, next to the ordinary medical and surgical case. At first many recommendations, as might be expected, were ignored, but with the death of a depressed individual, through suicide by jumping from a window, our recommendations gained in force. The depressed patients then very naturally gravitated to the ground floor. The admission of toxic deliriod states, the excited and agitated patients of the manic-depressive group, and schizophrenic types, gradually led to these cases being grouped still further, because they disturbed the other patients. Thus the establishment of a neuropsychiatric nucleus is the natural outcome even in spite of reluctance on the part of other services or the administration of the hospital in general, and it is felt that such a procedure will eventually take place in all of the larger hospitals of the country. It is to be borne in mind that the average physician and surgeon has little if any conception of the needs of this class of patient, therefore it is doubtful if a program such as outlined by Dr. Pratt can be initiated at the start without making opportunity for experiences such as the above. The licensing of the hospital for the care of nervous and mental patients naturally falls in line with other features. At least one-fifth of the total medical capacity of a general hospital can be definitely given over to neuropsychiatric patients, based upon our past figures, irrespective of the medical diagnosis on admission.

The observation of the neuropsychiatric aspects of general medical and surgical diseases permits of early contact with the patient at a time when he is not aware that he is being so classified and thus the early recognition of neuropsychiatric states is possible.

The groups of cases tend to fall in the following subdivisions: The psychoneuroses form at least 60 per cent of our cases and are usually associated with organic diseases as a back-ground. The failure to recognize this factor in the average hospital leads to unnecessary fixation and chronic invalid reactions. With the full evaluation of the patient as a whole, as well as the environment, we automatically get at the fundamental beginning of the difficulty and steps are taken to break up such fixation.

A large number of menopause reactions and involutionsal depressions are seen in the beginning because these individuals first report for gynecological observation. Often times the somatic references of this group cause them to seek medical supervision.

Depressive mechanisms are too often over-looked by the general practitioner and are merely attributed to high blood pressure. Every general hospital has a large hypertension and senile group and the usual recommendations upon discharge include little or no attention to the family situations involved and the legal aspects of will-making and guardianship provision are frequently forgotten.

Admission to a general hospital is often the retreat from unfavorable family situation through the excuse that they merely want a general check of their physical condition. Evaluation of the family mal-adjustments with suitable recommendations and advice should be an important part of every program of treatment.

In the observation of sick children in the pediatric department, the recognition of problem children, the birth palsies, and the mental retardations is another very important field. We can often check the mentality and the personality deviations through such admissions without the parents feeling sensitive because such is being done. It also serves as a means of evaluating the parents' reactions, for they are always willing to visit their sick child but would shun an ordinary interview of a psychiatric nature in a psychiatric hospital.

In every hospital practice, there are a large number of the constitutional psychopathic group who do much toward upsetting the normal routine and treatment, and are among the first to find fault with the care and treatment accorded them. When such troublesome problems arise, the neuropsychiatrist is the first to be called in consultation, and we have found it an excellent approach to the various services because they appreciate being helped out of such a quandary. Too often there are conflicting opinions between such services and as a court of last resort, the neuropsychiatric service acts as an intermediary agent and helps to settle the difficulty.

NON-MEDICAL WORKERS AND THE MENTAL HOSPITAL.*

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Much of the time of the average hospital psychiatrist is taken up with administrative matters, and this is usually at the expense of the attention that he might otherwise be giving to the more personal problems of his patients. By these personal problems is meant, broadly speaking, the solution of internal conflicts and a constructive hospital adaptation. It is pretty generally agreed that such personal attention is desirable, and so, if an improvement is to be made in this respect, the physician should either have administrative relief which would enable him to devote more time to the individual patient, or the use of non-medical workers for this personal treatment should be considered.

In regard to the first of these alternatives, many psychiatrists are frankly much more interested in administrative problems and there will always be need for such men. Others have more personal leanings but are unable to indulge in them because of administrative demands. In every mental hospital no small part of the routine duties of the physician, especially those relating to clerical work, housekeeping, and patients' material welfare, could be performed as well by competent lay assistants, leaving him freer to actually use his medical training and experience in treatment, and improving the deplorably cursory knowledge of individual patients that so widely obtains.

The second alternative—the use of workers without medical degree as aids to the physician in dealing with the personal problems of patients—is one that has led to sharp differences of opinion, and here, at the request of the Chairman of the Program Committee, the experience at St. Elizabeths Hospital will be largely used. Roughly, these workers may be divided into four

* Read at the eighty-first annual meeting of The American Psychiatric Association, Richmond, Va., May 12, 13, 14, 15, 1925.

classes: (1) Those with psychological training; (2) laymen more or less familiar with psychopathology; (3) psychiatric social workers; (4) nurses with special aptitudes for this work. These four groups will be considered in reverse order.

It is a matter of common observation that certain nurses (male and female) have unusual ability in gaining the confidence of some patients, in stimulating their interests and in controlling their behavior. Such activity is to be encouraged and is invaluable, but its range is environmental adaptation rather than internal conflicts and it should not include gratuitous advice and should be closely supervised by the physician. The use of psychiatric social workers in history-getting, in dealing with family situations while the patient is in hospital and in facilitating outside adjustment after discharge, is fortunately becoming more extended. In recent years a small number of workers—salaried and volunteer—with psychoanalytic experience have treated individual patients with considerable success, and certain of them—Dooley and Fay—have published observations.

Of workers without medical degree, those with psychological training have the greatest possibilities for skilled service. Here one encounters the much-mooted and much-booted problem of the "clinical psychologist." Apparently a large part of psychiatrists' objection to this person is concerned with his ability to commit patients to hospitals (in certain jurisdictions) as a result of an examination in which mental tests predominate. Undoubtedly, psychological yard-sticks are of limited value when applied to the total personality; but, on the other hand, a perusal of physicians' certificates is not a uniformly edifying experience. Our present interest, however, is directed elsewhere—to the intra-mural use of the psychologist, and the work of Franz and of Richmond may be cited in this connection. Mental defectives, with or without psychosis, are found in nearly all psychopathic hospitals; at St. Elizabeths the proportion is higher owing to the lack of other facilities for their care in the District of Columbia. But the rating of these cases—and not a few, especially of the higher grades, require much skill in testing—employs a minor part of the psychologist's time. Of increasing interest and value is the differentiation of original mental defect from mental deterioration, and the demonstration of special abilities and handicaps. These tests,

while still relatively crude, have practical application in suiting psychotherapeutic and social adaptation requirements to the patient's assets and potentialities. Many psychologists (because of exaggerated technical detachment or, on the other hand, a propensity for measuring the universe) have largely themselves to thank for the skepticism of psychiatrists; but such statements as ". . . we are not concerned in rating our patients or classifying them according to 'mental age' or I. Q., but discovering how much of a given ability is present and capable of function" (Winifred Richmond, Ph. D., "The Psychologist in the Psychopathic Hospital," *Journal of Abnormal Psychology and Social Psychology*, Vol. XVIII, No. 4, January, 1924) should contribute to a better relationship. Most of the psychologist's work is with newly admitted patients on the acute services, and includes history-taking, correspondence, mental examinations, progress notes, and especially helping them in an understanding of their situation and in beginning a constructive hospital adjustment, if possible. These last two points are usually much neglected in mental hospitals, and the patient must needs work out his salvation in hit-or-miss fashion. Not all patients, however, lend themselves to active therapy; indeed, it is quite possible to worry some into further psychotic manifestations. Discretion is useful here, as elsewhere.

From the point of view of medical administrative routine, these trained workers have disadvantages: they are disqualified for duty as officer of the day, as temporary heads of services and, of course, they cannot prescribe for physical ailments of patients—a considerable handicap, especially on acute wards. Moreover, they are not numerous, and are on the same salary basis as physicians. In mental hospitals the size of which requires a large medical staff, the foregoing limitations are less keenly felt; in smaller hospitals, with limited capacity for absorption, the worker without medical degree verges on being a luxury. However, what a worker can do is more important than what he cannot do; and the refinements of testing, which are only a part of the hospital psychologist's resources, are to the physician without special training much as physical examination is to the non-medical worker. The other resources referred to, which have for their main object intimate help to patients, are dependent on the personality of the psychologist, no less than on his training. Undoubtedly a lack of apprecia-

tion of the soma on the part of the non-medical worker causes some warping of interpretation of the patient as a whole, but, at least, in certain instances this has been compensated for by an excessive deference for the physical findings of the physician. Medical supervision, in any case, is essential.

In conclusion, it is highly desirable that the mental hospital patient should have more personal help in the solution of his internal conflicts, and in making a constructive adaptation. This applies particularly to the acute cases, and many of these who do not recover may be prevented from arriving at the so-called "backward" level. Moreover, our experience here has demonstrated that with such personal attention, many chronic, disturbed, untidy, deteriorating patients can in a relatively short time be made useful hospital citizens. This is all medical work in a broad sense; but at present the average psychiatrist does not have the time for it. In dealing with this problem the method of choice is to provide the physician with competent lay assistants who can relieve him of numerous routine non-medical duties and thus give him an opportunity to utilize with greater effect his special training, experience and resources. In conjunction with such a plan, or where it cannot be carried out as indicated, workers without medical degree (in whom personality factors are no less important than training) are undoubtedly of service; and while handicapped from the standpoint of medical organization, they are useful in other pertinent hospital activities.

RESEARCH PROBLEMS IN EPILEPSY.*

By CHARLES E. GIBBS, M.D.,

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Although it might be suggested by the title of this paper, it must be said at once that there is no intention to offer any of those bright ideas which only need to be worked out for us to understand the pathology and etiology of epilepsy. In our humble opinion such ideas, and the one-sided viewpoint which comes from attempting to prove them, are the greatest hindrance to real research and the source of much wasted effort. This may sound strange from one who has spent five years with the endocrine glands. This time has not been spent, however, in attempting to prove that dementia praecox is a disease of pituitary, thyroid, or any other gland, but rather in attempting to determine whether the various glands may in some way contribute to the psychopathic personality and the functional psychosis. The remarks to be made are based more on this experience than on a knowledge of epilepsy, and the suggestions to be offered are inspired by a hope of merely adding to the knowledge of the disease rather than of reaching any final solution of its pathology.

Just what our present knowledge of epilepsy really is, however, seems rather difficult to determine, and this would be the first step in research on any phase of the disease. The fit was probably the first functional nervous disturbance to be recognized, and it has been studied and explained in terms of each new phase of medical science. These earlier observers have undoubtedly recorded valuable facts which are buried in the literature and have not been carried forward because the interpretations offered with them have been discarded.

A greater difficulty is that the recent literature is so large and widely scattered. Papers on epilepsy have been appearing at the rate of about 100 each year for the past five years. Before the

* Read by invitation at the twenty-fourth annual meeting of the National Association for the Study of Epilepsy, Richmond, Va., May, 11, 12, 1925.

war, and before luminal, there were twice as many. For 1913 more than 250 papers are listed. These papers have dealt with every possible phase of the subject, from anaphylaxis to worms and weather conditions. The important fact shown by this large and varied literature is that epilepsy has been, and continues to be, studied by physicians representing several different branches of clinical medicine. Their observations cover a wide range in medical science and are expressed in a variety of terms. At the present time observations which demand consideration are being made from several points of view, those of psychiatry, neurology, metabolism, and immunity.

As a necessary preliminary to any comprehensive plan for research, or for the work on any one aspect of the disease, these scattered facts, whatever they are, both positive and negative, and this variety of current interest and opinion, should be gotten together and correlated. It may be said that this is unnecessary, that work in one direction cannot and need not consider that in another, that the psychiatric aspect is of no value for work in metabolism, or that until epilepsy is shown to be a disease of metabolism only the psychiatric aspect can be made use of. This all or none attitude, however, is not conducive to the most fruitful research. Clinical facts of one kind are often of value in understanding those of another kind. What has been learned by one method of investigation on one aspect of a disease may point the way to fruitful work in another direction by another method. It is submitted, therefore, that any program for research which this association might institute should begin by a collection of the available knowledge, and by a free exchange of current views. Upon this basis some plan for systematic investigation may then be developed. This principle of coordination is exemplified in the National Research Council, and a similar plan for research in psychiatry is fostered by the New York Psychiatric Institute. By building up in some such way an organized body of knowledge about epilepsy, this Association could serve a most useful purpose.

These remarks have been prompted by the conviction that in no phase of neuro-psychiatric investigation is it more necessary to have the clinical facts in hand, to heed them and be guided by them, than in research involving the endocrine glands. We know so little

about these glands that it is necessary to know as much as possible about the patient. All we know about the patient is to be considered in relation to all we know about the glands. We need to work from patient to gland rather than from gland to patient. In other words, it seems wise at the present time merely to consider whether the function of these glands may be involved in one disease manifestation or another, rather than to attempt to explain the total clinical picture in terms of too much or too little of one gland or another. This may be undue emphasis of an obvious principle, but there is so much tendency to this latter form of research and interpretation, as well as treatment, in the face of clinical facts which do not sustain it, that the emphasis seems warranted. It is necessary, therefore, even in working on this so-called physical aspect of functional nervous disease, to make use of a clinical and psychiatric viewpoint as well as a physiologic one.

In our work at the Psychiatric Institute we have proceeded from the view that the psychopathic personality and the functional psychosis are the end results to which a variety of factors have contributed. And the same view may be taken of the epileptic patient and the epileptic fit. Some of these factors are of a constitutional, biologic, or physiologic nature, including the primary instincts and the physiological component of emotion. Others are of an environmental or psychologic nature, matters of experience, sources of instinctive and emotional stimulation to which the biologic organism has responded, in action or in thought. The result, the habitual mode of response, constitutes the psychopathic personality, and a closely related mode of response is the psychosis, or the fit.

This rather objective and behavioristic viewpoint has been found useful in formulating from clinical manifestations which are largely of a psychological order some idea as to the nature of any physiological disturbance which may be present, as well as in correlating observations of a physiological character with the clinical symptoms. This viewpoint seems useful in working from psyche to soma and back again, as a connecting link between psychological manifestations, reactions and complexes, and any biological factor which may be operative or may have originally conditioned them. Any part played by the endocrine glands would be of a biological

nature, but other factors have also been operative and are manifest in the end result. With these the gland factor should show some correlation, and so from them we should get some clue as to its nature.

To get any very definite idea of the gland factor from what is known of the glands themselves has been found rather difficult. Our present knowledge of the function and diseases of the endocrine glands has not seemed to warrant the formulation of any working hypothesis that the functional psychosis is simply an acute glandular disturbance. Such may prove to be true, but there does not seem to be any simple or short-cut way of demonstrating it. Our knowledge of the specific function of each gland is quite limited, and so we are limited in clinical and laboratory methods, the results of which can be interpreted in terms of one gland or another.

What we do know about these glands is that they play a very fundamental part in the vital processes of the body and in its biological evolution, that they have an essential function in growth and reproduction, and finally that the nature of their function is metabolic or biochemical. These glands thus contribute an essential and integral part to biologic function and biologic constitution. It is on this basis that their exhaustive study in patients with functional nervous disorders is indicated.

Working on this basis we have attempted to approach endocrine function by a study of those physiological processes in which the endocrine glands are involved. The direction which these observations have taken has been suggested by the clinical manifestations, and we have sought to correlate the results more with the clinical facts than with one gland or another. Following this plan we hope to be led to more specific and concrete problems. In this way we have studied the biologic aspect of sex and sex behavior. We have studied the growth of the patient and his resulting physical make-up, and have sought to correlate his biologic evolution with the evolution of his personality and the phases of his psychosis. We have found a low basal metabolic rate in certain cases but have not been able to conclude that it means thyroid. What it does mean remains to be explained. We have found some evidence of a disturbance in the metabolism of fatty or lipid substances in certain phases of dementia praecox. This may involve the suprarenal, and

it may involve also the brain and the testis and ovary, the functional metabolism of all these being of a lipoid nature.

This statement of our method of approach in the functional psychoses is made only to suggest that a similar method may be applied in epilepsy. Considerable hesitancy is felt, however, in formulating any concrete suggestions. To proceed from the clinical point of view, as well as that of the patient, it would seem that the fit is the thing to be understood. A better knowledge of its fundamental nature should indicate the direction in which to find its cause. Leaving aside the question of cause, there can be no question that in the epileptic fit some profound disturbance occurs in the brain which is of a physiological nature. It is important, therefore, to approach the fit from the standpoint of brain physiology. But we have practically no brain or nerve cell physiology with which to work. Brain function is expressed in terms of structure, fiber tracts, cells and reflexes, and in terms of the result of brain activity, behavior, ideas, and complexes. But neither of these is adequate to express what happens in the brain in the epileptic fit. We find the fit expressed as a "motor explosion" or as "a liberation of motor energy determined by the release from control of motor centers normally dominated by higher levels in the neuropsychical hierarchy," or as a "muscular anarchy" liberated by a regression to a state of infantile pleasure.

Everyone will probably agree that before we can seriously consider the brain in the epileptic fit, and in other types of functional reaction as well, it will be necessary to develop another phase of brain physiology, and new methods by which to observe brain function. We know very little of the internal life of the brain, of the metabolic changes which take place in the cell and fiber under varying physiological and pathological conditions, of food requirements and waste products. We have only vague ideas as to the meaning of the peculiar chemical composition of the brain and the large blood supply. But from what we know of the convulsive type of reaction and the means by which it can be produced, especially such physiological means as a reduction in the supply of sugar or of oxygen, it is evident that the biochemical aspect of brain physiology is important. It thus seems less necessary to assume the presence of some mysterious toxin, since convulsions are seen to result from an interference with brain metabolism.

It is on this biochemical basis that the endocrine glands may have some relation to brain function and to the epileptic fit, but at present no very close correlation can be made. Our present knowledge does not seem to justify any very definite working hypothesis that epilepsy is simply and essentially a gland disease. Careful work on the metabolism of the epileptic patient, his requirements of, his capacity to use, and his reaction to, the various essential elements of diet, would be a real contribution, whether the results were positive or negative, and should point the way to more specific problems.

In addition to the epileptic fit we have the epileptic patient, who is said to have a characteristic personality, even before the seizures begin. It is on account of the close relation of the epileptic personality to other types of psychopathic personality that epilepsy is of great psychiatric interest. The work on heredity indicates that the constitutional factors in the various forms of psychopathic personality are of a common nature and closely related. Only slight variations may determine the various forms. The psychological attributes of the various forms also seem to have many common factors. If the epileptic personality could be more clearly differentiated from other types, we should be afforded more definite ideas as to why one psychopath has convulsions while another has psychotic episodes. It is evident, then, that the study of personality is quite fundamental and of common interest. A study of personality in psychotic patients who have convulsions should be of considerable interest, and so should work on the previous personality of epileptic soldiers.

For the discovery of those biologic factors which contribute to personality, and of any gland factor, the psychiatric point of view suggested above seems useful. It should prove particularly profitable to follow the development of the behavior habits of the epileptic patient in relation to his biologic development. It is of biologic significance that these psychopathic traits begin to be manifest even in infancy, that epilepsy begins during the period of growth in a large majority of cases, and that seizures appear at puberty in so many of them.

Certain facts suggest the importance of considering the development of the brain from this standpoint. It is stated that the

closest equivalent of epilepsy is imbecility, the two constantly occurring in relatives or in the same subjects; that only one-fourth to one-fifth of all epileptics have a normal psyche; that when severe epilepsy begins early in childhood an arrest of development occurs and few escape idiocy. We know comparatively little, however, of the factors which influence brain growth in its various phases. The work of Jackson and others on the effects of inanition and malnutrition on growth and structure might offer helpful suggestions. There is a certain amount of evidence, which we have recently reviewed, that the suprarenal gland has some relation to brain development, especially in the foetus. Some ten or fifteen papers, however, have appeared within the last two years on the treatment of epilepsy by removal of one suprarenal. Removal of both would cause death. From the standpoint of biochemistry, it would seem that the epileptic needs more suprarenal rather than less, and that the suprarenal of the foetus would be preferable.

It has been the object of this discussion first to suggest that the available facts and opinions about epilepsy be gotten together as a basis for some coordinated and comprehensive plan for research, and second to point out that research involving the endocrine glands should be developed from a broad clinical and biological point of view.



EPILEPTOID REACTIONS IN CHILDREN.*

By V. C. BRANHAM, M. D.,

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The term "epileptoid" in this discussion is used in its generic sense, a grab bag in which is collected a miscellaneous assortment of manifestations epileptiform in character. This procedure seems logical enough when one considers the fact that epilepsy in itself is largely an idiopathic affliction. One could speak with much less assurance of diphtheroid symptoms where the etiology of the original disease is so well known.

There must come home very strongly to the various workers in the field of the mental hygiene of childhood the prevalence of a certain syndrome of behavior disorders which occurs with a frequency rather startling. One is tempted to classify these as auto-toxic, epileptiform, choreiform, hysterical, or neurotic, according to his point of view, but certain it is, they bear a peculiar relationship to the various aspects of the well-defined epileptic attack. This fact, of course, has been recognized for years, but it would appear that the more subtle expressions of the trouble often pass unnoted by physicians who have come to look upon the seizure as the final criterion of judgment in the matter.

The foundation for the more accurate diagnosis of this relatively large symptomatic group, which has remained hitherto unclassified, was laid by Jackson when he discovered that loss of consciousness was not necessary to delimit this syndrome from others of like nature, such as chorea or hysteria. The study of myoclonus, to be followed thereafter by the concept of the "epileptic equivalent," served to strengthen this belief. Psychiatry then contributed its quota by bringing out the epileptic personality as a distinct psychic entity.

In this manner, there has arisen a very definite cleavage from the old idea of the seizure or loss of consciousness as being hall marks of this disease.

* Read at the Annual Convention of the National Association for the Study of Epilepsy, Richmond, Va., May 12, 1925.

Cases appearing in the children's guidance clinics which exhibit the epileptoid reactions may be more or less arbitrarily divided into three groups. The first of these is a latent type of epilepsy, rather picturesquely called masked epilepsy. Frequently it takes a nocturnal form. Its true nature is not recognized by the mother as she has never seen the actual seizure. All that she knows is her child acts peculiarly and is not himself at times. Of course, this is epilepsy proper, but the subjective and objective symptoms presenting themselves to the clinician are essentially epileptoid and the real diagnosis is often missed. Especially significant in this relationship are night cries, somnambulism, inarticulate talking in the sleep and frequent falling out of bed. A point of differentiation from the nightmare is the prolonged period of confusion following a nocturnal seizure which is not present when the child is awakened from a dream. Frequently when the mother makes up the bed she will find it unusually dishevelled some mornings, or perhaps a frothy stain with a fleck of blood on the pillow case will point out the source of the trouble. Damp bed linen from excessive perspiration or enuresis on occasion is quite suggestive. Children subject to these attacks will arise slowly some mornings, feel heavy and stupid, be slow in dressing, exhibit a pallor and react generally in a manner which stands in marked contrast to the spry, alert attitude of other days. The periodicity of such a picture is of primary importance.

The second group, likewise, is typically epileptic in that it has the *petit mal* features. Here again the mother does not notice the brief suspension of consciousness, and it is only by the most careful questioning that this symptom can be brought out. The usual picture presented to the clinician is the epileptoid syndrome.

In the third group of cases no demonstrable seizure can be elicited. These are the epileptoid reactions proper. Nevertheless, certain features of typical epilepsy bear analysis in their relation to this group.

There are the prodromal symptoms, for instance, especially the *aura* of the grand mal attack. On the morning of the day when a seizure is to occur the subject may awaken with a headache, nausea and dizziness. Sometimes he feels jumpy and unusually irritable, or may be in a dazed condition. Flashes of light or color are not infrequent. This condition may go on to the actual seizure, it may be

aborted by medication or the removal of extraneous stimuli by lying down in a darkened quiet room, or it may spontaneously clear up. If the seizure takes place, there are the usual symptoms of the wide dilatation of the pupils, great pallor, followed by the fall, the cry, loss of consciousness, cyanosis, tonic muscular contraction superseded by the clonic spasm, involuntary evacuations, and so forth. As the violence of the seizure wears off and consciousness returns, there is a rather prolonged period of confusion. Frequently a severe headache sets in that may last through the day. This reiteration of the quite familiar symptoms of epilepsy seems desirable in order to correlate them with the group we are now studying. The epileptoid reactions most closely simulating aura are transient dizziness, sense of fullness in the head, unusual pallor without sufficient apparent cause and dilatation of the pupil. By no means infrequently, they may be unaccompanied by any other symptom. The actual seizure is represented in the epileptoid syndrome, of course, by jerking of various muscle groups or a more diffused myoclonus. These are the analogues of the clonic spasm. Transient confusion in the epileptoid group is rather rare, and if present the petit mal is quite likely to be its accompaniment. Severe headaches, unexplained by eyestrain, loss of sleep, or hypopituitarism, are often a definite part of the epileptoid picture.

The personality make-up of the epileptoid child is rather remarkable. Above all he is emotionally unstable. He cries upon the slightest provocation, or is ready to fly into unprovoked tantrums of anger. His feelings are very easily hurt and the reaction on such occasions is far too marked for the insult offered. Occasionally he will fight when so offended, but usually he will cry and bring his troubles home to his mother. Often he will brood for days over a trivial injury. He craves sympathy and is stubborn and wilful in attaining it or the satisfaction of other wants. The imagination is not infrequently well developed and around it is built a desire for attention or a boastful striving for the spotlight. In contradistinction to the egocentric attitude of the hypomanic child, is the easy discouragement of the epileptoid. He will impulsively rush into things without consideration, but he turns back baffled by the slightest obstacle. This leads in many cases to unwonted shyness and a feeling of uncertainty. A peculiar characteristic is the over-determination of any act. A period of vacillation in which little is

accomplished is followed by an impetuous expenditure of energy totally out of proportion to the requirements of the situation. Thus the whole behavior of the child tends to be very uneven and poorly poised. In many of the older children the sense of responsibility and moral judgment seem to be poorly developed. Lying assumes in these instances almost pathologic proportions and stealing is by no means rare. While some of these children may be quite bright mentally, most of them are moderately retarded, especially if repeated epileptic seizures have occurred in the past.

On the physical side the deep reflexes are nearly always exaggerated and tests of co-ordination are poorly done. The instability of the sympathetic nervous system as noted in the vaso-motor changes, such as the pallor noted above, likewise may find its reflection in dilation of the pupils or in hippus. Dermatographia is frequently present. Most of the epileptoid children seem to be rather anemic and thin. A blue shading creeps under the eyes which do not have the luster we would expect in the normal child. This is particularly true of the child suffering with the nocturnal form of epilepsy.

In running over the histories of children showing epileptoid reactions, three phenomena stand out rather clearly. First, a large proportion of these cases have had seizures in infancy or early childhood. By this is meant a series of convulsions extending over days, months, or even years. One must be on his guard against drawing false conclusions from the solitary convulsion due to an attack of indigestion or to the cutting of a tooth. On the other hand, one should remember that the mother who is always hesitant about admitting a fault in her offspring, is inclined to minimize all such symptoms. A certain proportion of these seizures pass over into the recognized nocturnal form while a goodly number cease spontaneously and leave a residue in the epileptic equivalent or the epileptoid reaction. We are coming to believe that the number of cases ceasing without any demonstrable sequellæ is relatively small.

The second point to be noted is the prevalence of epilepsy in the family of the epileptoid child. More frequently there is a neurotic tendency present which the child has apparently inherited. In fact, the study of the personality make-up even in early infancy before the epileptoid reaction has arrived brings out this

predisposition. The history will also show in numerous instances a severe illness of scarlet fever, typhoid or pneumonia in which the fever is high and delirium has been present. The normal child recovers without untoward effects, but the neurotic child with epileptic familial background tends to develop epileptoid reactions. Severe afflictions of the nervous system such as anterior poliomyelitis, cerebrospinal meningitis and encephalitis, of course, are very likely to produce these reactions in either the normal or the neurotic child.

The third point to be brought out is the large proportion of children in this group who are retarded in intelligence. In fact, backwardness in school may be the very reason the mother takes the child to the clinic. The deleterious effects of repeated and prolonged seizures need no further comment, but one should recognize that petit mal attacks and severe epileptoid reactions seem also to exert a retarding influence upon the intelligence.

Perhaps a word should be said about the differential diagnosis between this group and those of chorea and hysteria. The two essential points to recall in the epileptoid child is the periodicity of the symptoms and the history of seizures either early in his own life or in that of some member of the family. The differentiation of these early seizures is rendered easier by the fact that most choreiform and hysteroid seizures occur after eight years of age. In chorea and in those forms of the epileptoid in which muscular spasm is present the motor areas of the cortex seem to be involved in each instance. The choreiform movement, however, is irregular and spasmodic, totally unlike the rhythmical spasm seen in the epileptoid. At night the child suffering with chorea is in comparative comfort while the reverse is often true of the epileptoid. In both the hysteroid and the epileptoid there is a marked tendency for a neurotic background, which may become rather misleading. In children hysteria usually makes itself known as an affliction of digestive or respiratory systems. Puberty and early adolescence, however, may bring the well-developed hysteroid spasm which is vaguely defined, inconstant and lacks that definitely located rhythmical characteristic of the epileptic spasm.

How shall we treat these children? It would seem desirable in those cases in which a history of seizures has been elicited or in which the myoclonus and other muscular spasms are marked to

bring these under control by intensive medication as soon as possible so that the child's physical reserve has an opportunity to build itself up. Guarded Luminal administration for a brief period until the most marked symptoms are alleviated is often advisable. The child can then be placed upon a glandular formula such as Pituitary Substance whole gland, with a small amount of Parathyroid Substance and Calcium Lactate. The important point in this therapeutic régime is to determine the child's physiologic limit by pushing the medication and then adjusting future dosage accordingly. Frequently the nervousness increases under medication, but if the treatment is suspended for a few days resumption of the glandular formula may bring about rather striking improvement. At best the effect of such treatment is problematical as all endocrinologists know. Another supportive treatment which often gives better results is founded on the observation that these epileptoid children are constipated about as often as those suffering actual seizures. High enemas are of service in this connection. They seem to secure a better cleansing of the lower bowel than is afforded by the purge. Magnesium Sulphate may cause a mild dehydrative process with redistribution of the blood which is helpful in aborting incipient attacks. Other hygienic measures of general nature need not be discussed. To the writer it would appear, however, that certain procedures, scarcely to be classified as medical, are productive of results in many instances. Reference is made to the possibility of reducing the tension under which these children often labor. The mother can make it a regular routine for her child to lie down in a darkened room during the fatigue hour of each afternoon. Exciting movies and books, taking the child on shopping tours, loss of sleep and other factors of like nature that raise the tension of the child are to be avoided. He can be taught methods of relaxation when the tenseness of emotional stresses such as anger sweep over him. Methods of avoidance of mental distress and conflicts are as essential to the epileptoid child as to the neurotic adult. A better social adjustment of the child to his playmates is imperative. His quarrelsome, stubborn nature brings him into constant conflict which leads others to shun him. This, of course, reacts unfavorably upon him. The assignment of the child to Scout activities or skilful direction in the games of the Y. M. C. A. may be all that is necessary. It must

also be recalled that the mother is possibly neurotic or epileptic and that her method of handling her child may be such as to keep him under tension a good part of the time. Talks with her or even removal of the child from the home environment may be necessary.

It can readily be seen that the epileptoid child is most frequently thought of by his teacher, parent and other associates, as being merely a problem case, whereas the true facts are he is mentally ill. If this discussion has made any one point clear, it is the need of psychiatric service for all behavior problems in children—a service not rendered by the teacher, psychologist, probation officer, nor even the school physician.



THE CRIMINAL AND CLINICAL RECORD OF JESSE MURPHY: A DESPERATE FELON.*

By N. S. YAWGER, M. D., PHILADELPHIA.

Jesse Murphy was a dramatic, fluent, egotistical, audacious, selfish, cowardly, cunning and cruel thief and murderer; and at times a malingerer and a lunatic. And governors, congressmen, judges, lawyers, physicians, wardens and keepers, have painful and sometimes vexatious recollections of this most troublesome desperado.

Family history: The father, now dead, used alcoholic beverages to excess. The mother is married the second time and is not known to show abnormalities nor deviations. There are two sisters who are in the theatrical profession but neither has risen above a minor part. One must have had an uncontrollable temper since she stated that she hit her brother, ten years of age, in the head with a milk bottle.

Murphy, who afterwards came to have eight other names, was born in Worcester, Massachusetts. He is 39 years old and states that about 18 of the last 25 years have been spent in prison. At 14 years he was an altar-boy, when "something went wrong," what that was he will not state, and he was sent to Lyman Reform School upon the charge of breaking and entering. He proved most refractory, after eleven months was transferred to the Reformatory at Concord and a year and four months later was placed on the State Farm for the Insane at Bridgewater with the diagnosis of adolescent insanity. From this institution Murphy was later paroled but in five days was returned. Following this, he was transferred to the Worcester County Jail and from there was finally discharged. Since simulation of insanity is later to be a most vexatious feature of this case, the comment may not be amiss, that at the youthful age of 16 years, to have been in a mental hospital—twice counting parole—through malingering, would be an extraordinary circumstance.

In less than two years from his release, Murphy was sent to Deer Island House of Correction for larceny.

* Read before the Philadelphia Psychiatric Society, May 8, 1925.

Four months after serving his second sentence, he was ordered to the Charlestown State Prison for breaking, entering and larceny. And during this term he was again sent to the Bridgewater Hospital for the Insane. A note made at the hospital at that time was to the effect that he was unreliable, impulsive, erratic, inhibitionless and violent. He was regarded as a malingerer, but that the malingering was based on a strong psychopathic taint.

About a year and a half following his release from his second sentence, he was sent to the Deer Island House of Correction for receiving stolen goods. But it appears that he was soon transferred to a prison camp from whence he escaped.

Six months later, he was detained in Omaha, Nebraska, for carrying concealed weapons, and shortly after, he was in difficulty—nature not known—with the police in Toledo, Ohio.

In May, 1917, he "held up," robbed, and then shot a bank-messenger in this city, the nature of which crime was such as to call in question his mental condition, by reason of the unnecessary shooting of the messenger, as I have been informed by fair-minded! "hold-up" men. Murphy was admitted to the Eastern Penitentiary after having been convicted of robbery, aggravated assault and battery with intent to kill, and for carrying concealed deadly weapons. The term of his sentence was from 12 to 13 years. Through subsequent events, Murphy's name has become important in the annals of medical jurisprudence.

Within a month of his admission to the prison, he was removed to the prison hospital for observation. At that time he was apprehensive, restless, excited, evasive, suspicious, said he was afraid of being killed and talked to others about getting knives and pistols with which to defend himself. But he created so much disturbance in the hospital, that soon isolation in a cell was necessary.

My first examination of Murphy was made three months after his admission to the prison. At that time he lay naked upon a mattress and would not speak. When spoken to, he started up suddenly, with his eyes staring wildly and with a terrified expression. He was a shameless masturbator. Once he pounded his head with the heel of a shoe until blood oozed from his scalp. There being abundant opportunity to watch him unobserved, his behavior was most carefully studied. At one time, while lying

quietly in his cell, a fly was seen to crawl across his cheek and over the exposed eyeball and he never moved an eyelid. His feeding had to be forced and for a short period he was tube-fed. Finally, the nursing he required made hospital care again necessary and ultimately he drifted into a semi-stuporous state. Physical examination showed that his pupils were widely dilated, his extremities were moist and cyanosed, his tendon reflexes were markedly exaggerated and he had become very stout. The following note was made by me at that time:

The simulation of insanity is very difficult to maintain for any considerable time and is of necessity very wearing upon the patient. During this period of Murphy's psychosis, he has gained 36 pounds so it does not appear possible that he could have been practicing deception at this time.

As I had good occasion to afterward recall, I once found Murphy in a state of great apprehension. Upon inquiring as to its cause, he told me he had committed two murders in Boston, and for which crimes two brothers, named Rollins, had subsequently been tried and convicted. Thinking at the time that it was one of his vagaries, I forgot the circumstance, but the same statement later developed a very grave situation.

By this time the psychosis was so pronounced and had been of such long duration, that a commission was applied for with the result that he was found insane and ordered to the State Hospital for the Criminal Insane at Farview. After having been there some months, Murphy improved so that about ten months from the time he had been received, he was returned to the penitentiary with the statement that he had only been simulating insanity. We afterward learned that while at Farview he was most objectionable and was considered highly dangerous. He was a great agitator and had procured a revolver which was with difficulty taken from him.

Shortly following his return to the penitentiary, I examined him and found him excited, suspicious and occasionally assuming the attitude of one the subject of auditory hallucinations. Once he told me he could hear the city hall officials plotting against him. He was exceedingly troublesome and could not be kept in cells with other prisoners. He was quarrelsome in the prison yard, was a pest to the officials and was so threatening in his attitude that he was placed in the prison hospital. But here, again, the trouble

grew worse and he had to be isolated in a cell. He was so treacherous and dangerous that everyone who came in contact with him was very fearful of him. And at this time I wish to remark that from having examined thousands of lunatics and hundreds of criminals, I have found that, whenever an individual is feared by *all* who come in contact with him, he invariably has a pronounced mental condition.

However, there were times when his behavior was regarded as assumed. For instance, his act of "cracking a safe" I never considered the outcome of automatism. At such a time Murphy would walk to the wall of the ward, make the motion of throwing a rope up to a window, and after it had caught, would cautiously ascend, open the window and enter the room. Then, imagining himself before the safe, he would make the movements of boring into its side. When he came upon the money, his face would assume the most happy and triumphant expression and he would proceed to place the money in his pockets. Sometimes during the procedure, he would stop abruptly, would watch and listen, and any slight noise would cause him to cease his activities and appear very apprehensive. Of course, one would not expect after the prisoner had been diverted by a noise, that the state of automatism would promptly reassert itself.

During the development of his second pronounced psychotic period, the following note was made by Dr. Horace Phillips:

The prisoner is untidy in his appearance and unclean in his habits. He runs up and down the ward, dances and shouts. He grimaces. Sometimes he is in the attitude of listening to voices and shouts back at them. He defecates in the clothes of other convicts and urinates in cups. He assaulted a nurse, hit him and kicked him in the abdomen. There have been incoherent periods.

Murphy continued so unmanageable and so dangerous that a commission was again requested. At one meeting held by the commission, Dr. W. T. Lynch, Medical Superintendent at Farview, who had contended that he was only a simulator, was requested as a witness, so that he might express his opinion as to the behavior of the prisoner. Among other matters, Dr. Lynch testified that after Murphy had been under his care for six months, they began to suspect that he was a malingerer, that recently he had examined the prisoner at the penitentiary, and if he were not then feigning, he had deteriorated since his return from Farview.

But even if Murphy's condition were worse and he were not feigning at the present time, Dr. Lynch believed the prison could take better care of him, because he had not the facilities the prison possessed for the care of a patient of that kind. However, this testimony did not mitigate against the finding of insanity and the prisoner was returned to Farview.

While there the second time, Murphy took affidavit to the confession that, in 1917, he was the murderer of the managers of a chain of stores in Boston, and of which two brothers, named Rollins, had subsequently been tried and convicted, and for which one was to be electrocuted while the other was to undergo life imprisonment. This statement was the same that Murphy had previously made to me. The authorities at Boston were communicated with and agents were sent to interview Murphy at Farview. He gave so many details of the crime that they were impressed with his story, and, as a result, a special act of the Massachusetts legislature stayed the execution of the one Rollins boy, until Murphy could be brought on and tried for the murders he now confessed. Upon the strength of all this, he received a pardon for his felonious offense in Pennsylvania and was taken to Boston to stand trial. Murphy's counsel requested me to testify, but the case had already caused me much annoyance—as indeed it had all who came in contact with it—and I refused. Murphy changed counsel at least once and then insisted upon conducting his own case. Before being placed on trial a mental study was made and he was pronounced sane. The case was called, when Murphy very dramatically refuted his previous confession, by declaring he had not committed the murders. Since the only available evidence of his guilt had been his own confession, he was judged not guilty and was discharged. Except for the fact that he had previously escaped from a jail in that state, he must have gained immediate liberty, but the unexpired term of four months made his temporary imprisonment possible. Soon, however, release was necessary and then Murphy signified his determination for complete reformation. He remained quietly with his mother near Boston for a few weeks, then suddenly appeared in this city, after which he was for a time lost from sight. But he did not remain idle long for soon hold-ups and a murder in Michigan, bearing the earmarks of his work, were being broadcast. And then came his downfall.

At that time he was operating as a hi-jacker, that is, he preyed upon rum-runners and bootleggers. But this can be better described by Murphy than by me. In a published interview he said: "You want to know something about hi-jacking, eh? Well, you've come to the right man. But before I start to tell you the secrets of the hi-jacking business—if they can be called secrets—I want to say in the first place that the whole game is founded on a spider-web of double-crossing. From start to finish, from the most petty underworld tipster or hanger-on to the birds who engineer the big jobs, a fellow has to keep his eyes open constantly in anticipation of being double-crossed. Dog eat dog—all the way through—that explains it. It's one crook's wits against another's all the time. And he who thinks fastest and sometimes gets out his gat first, wins. To the average man it may sound illogical when I say the hi-jacker regards his profession as perfectly legitimate. The men he preys on are breaking the law; the rum-runner, the booze-camp operator and the whiskey-maker are all without the pale. And so, taking it for granted that the hi-jacker may perhaps have one or two scruples, he doesn't feel he is as great an outlaw, from the sociological point of view, as the man who holds up pedestrians or who robs legitimate business places. Not that I am seeking to put hi-jackers in the light of angels, but I merely want to get across, if I can, the psychology under which he works. The liquor men, everyone of them, are piling up fortunes illegally. So why should we hesitate to relieve them of a part of it?"

In my own case, of course, I cannot plead that the prohibition law drove me into a life of crime. It merely changed my method of working. It would be foolish for me to say if it were not for the liquor traffic I would be pursuing an honest calling. Not with a record of 18 of the last 25 years spent behind the bars. The liquor traffic as it has developed since the passage of the Volstead Act, has, in my case, merely served to stimulate my activities. It has created for the average criminal a veritable paradise of possibilities. When, before 1918, was there so rich a field for the highway-man, the stick-up-man in which to work?" Murphy, continuing later, added:

Each member of the hi-jacking gang, usually four or five, provides himself with a shiny badge. He then hides at a convenient point on the route the runner is supposed to take. And when he comes bowling along with his heavy truck, we flash our guns and badges. Prohibition officers,

see? Even if the truck is guarded by a gunman or two, we always have the drop on them. Nine times out of ten they run. Then we confiscate the truck and load and take it to its original destination, or elsewhere, if we can get a better price. As for the blind-pig or booze-camps, they are easier to handle. Usually one or two of us go to the scene of the prospective job some hours, or even a day or two, before we decide to operate. We drink and hang around awhile to get the general lay of the land. And one thing we never overlook in this reconnoitering—the cash register. We keep close tabs on how much money the place takes in during an hour or two and this is always a factor in determining whether or not we will stick-up the joint. If they are doing good business, that is all we want to know.

Murphy had been in a number of these jobs when he and his gang entered what is known as a blind-pig, that is, an illegal saloon. To divert attention as a preliminary to the robbing, they created a little disorder by firing a few wild shots, but unfortunately for them these were heard by the police, who then rushed in and a battle ensued. Finally, Murphy and one other robber were shot as was a patron of the place. The desperado was then captured and placed under heavy guard in a hospital. As he was already wanted for the killing of an officer sometime before, he admitted that he was the notorious Murphy and confessed to the murder. But, with his accustomed audacity he added: "I have faced three killing charges before and have always gone free, so I don't worry much about this one."

His defense was to be insanity but he was found sane and was tried. Murphy was convicted of first degree murder, but in Michigan, the extreme penalty for this is life imprisonment.

As to Murphy's notorious murder confession, there are three possible explanations: (1) That it was a lie; (2) that it was a delusion; (3) that it was true.

In regard to certain important matters in this case, I differed from some others. I believe at times Murphy simulated insanity. I believe at periods he was markedly psychotic, and twice took affidavits to that effect. I believe when free from his manic or depressive phases, that he was always hypomanic. As to the Boston murders of which he confessed and subsequently refuted his confession, I am inclined to believe he was guilty of them. However, be that as it may, it must be added that the Rollins boy who had been sentenced to be electrocuted for these murders in 1917, is still alive, and recently I have been informed, he and his brother have applied for pardons.



Association and Hospital Notes and News.

THE EIGHTY-SECOND ANNUAL MEETING OF THE AMERICAN PSYCHIATRIC ASSOCIATION.—The next annual meeting of The American Psychiatric Association, the eighty-second, will be held at the Waldorf-Astoria, New York, June 8, 9, 10, 11, 1926.

Those who have suggestions for exhibits at this meeting are asked to communicate with the Chairmen of the Committees on Pathological Investigation, Statistics, Occupational Therapy or Nursing. General suggestions about exhibits will be welcomed by the Chairman of the Committee on Program or by the Secretary.

It is possible that applications completed and in the hands of the Secretary, Dr. Earl D. Bond, 4401 Market Street, Philadelphia, Pa., by April 1, may be considered to comply with the regulations adopted by the Association last year.

Committee on Reorganization.—The Committee on Reorganization has had several meetings and will have much to present to the Council at a meeting to be held Monday, June 7, at 2 o'clock. The Council in turn will have important recommendations to present to the Association.

Program.—The Program for the New York meeting will contain several innovations. Dr. George E. Vincent, President of the Rockefeller Foundation, will deliver the annual address on Wednesday, June 9.

Because of hasty reading of a communication from the President elect, the JOURNAL erroneously stated that the meeting would be on June 7, 8, 9 and 10, 1926. The correct date is given above.

CANDIDATES FOR ELECTION AS FELLOWS OR MEMBERS.—The following is a list of candidates who have applied for Fellowship or Membership in the American Psychiatric Association. It does not include candidates for Fellowship proposed at the 1925 meet-

ing whose names appear in the published proceedings, who will come up for election at the meeting in June:

S. Spafford Ackerly, M. D., Bloomingdale Hospital, New York.
C. H. Anderson, M. D., Anna State Hospital, Ill.
Leo Henry Bartemeier, M. D., Johns Hopkins Hospital, Md.
Max Bennett, M. D., Boston Dispensary, Mass.
M. O. Blakeslee, M. D., Home and Training School, Lapeer, Mich.
Douglas D. Bonnyman, M. D., State Hospital, Middletown, N. Y.
H. B. Brackin, M. D., State Hospital, Raleigh, N. C.
Asher T. Childers, M. D., Bloomingdale Hospital, N. Y.
Eric Kent Clarke, M. D., Canadian Nat'l Comm. for Mental Hygiene, Toronto.
Betsy Coffin, M. D., Fergus Falls State Hospital, Minn.
George E. Daniels, M. D., Bloomingdale Hospital, N. Y.
A. W. Foertmeyer, M. D., Cincinnati, Ohio.
Thomas M. French, M. D., Bloomingdale Hospital, N. Y.
Raymond I. Gosselin, M. D., Bloomingdale Hospital, N. Y.
Alva Gwin, M. D., Augusta State Hospital, Maine.
Louisa E. Keasbey, M. D., Binghamton State Hospital, N. Y.
Kenneth Keill, M. D., Binghamton State Hospital, N. Y.
Charles E. Kiely, M. D., University of Cincinnati, Ohio.
Percy Lawson, M. D., St. Lawrence State Hospital, N. Y.
Clara Louise McCord, M. D., Pennsylvania Hospital, Pa.
Monroe Meyer, M. D., U. S. Veterans Hospital No. 81, N. Y. C.
George Mogridge, M. D., Iowa Inst. for Feeble-minded, Iowa.
Henry B. Moyle, M. D., Ontario Hospital, Mimico, Ont.
L. E. Ragsdale, M. D., Tenn. Home for Feeble-minded, Tenn.
Leonard R. Ravitz, M. D., Cleveland, Ohio.
Harry Rubin, M. D., U. S. Veterans Hospital No. 74, Miss.
C. E. Shinkle, M. D., Cincinnati, Ohio.
Charles W. Stephenson, M. D., Bloomingdale Hospital, N. Y.
Kenneth J. Tillotson, M. D., McLean Hospital, Mass.
Frank L. Whelpley, M. D., State Hospital, Goldsboro, N. C.
David L. Williams, M. D., U. S. Veterans Hospital No. 44, Mass.
C. L. Whitmire, M. D., U. S. Veterans Hospital No. 62, Ga.
August E. Witzel, M. D., Brooklyn State Hospital, N. Y.
Frederick W. Seward, Jr., M. D., Goshen, N. Y.

ADDITIONAL MEMBERS OF COMMITTEES.—Through inadvertence the following names were omitted from the membership of certain committees of The American Psychiatric Association, as published in the October JOURNAL:

To the Committee on Legal Aspect of Psychiatry the name of Dr. L. Vernon Briggs, of Boston, Mass., should be added.

To the Committee on Arrangements the names of Drs. I. J. Furman and Edith R. Spaulding, both of New York, should be added.

The President has appointed a Committee on Publicity as follows: Dr. George K. Pratt, New York, Chairman; Dr. C. C. Burlingame, New York; and Dr. Clarence A. Bonner, Medford, Mass.

OCCUPATIONAL THERAPY.—Dr. William Rush Dunton, Jr., Chairman of the Committee on Occupational Therapy, has asked for the publication of the following timely and suggestive note:

In order to advance occupational therapy as a science it would seem that psychiatrists, who have used this form of treatment for so many years, should be more active in contributing to the exact knowledge of this important therapeutic measure. The occupational therapy committee therefore requests that hospital superintendents stimulate their respective staffs to engage in research upon some of the many sides of the subject. Dr. Bond, of the Pennsylvania Hospital, and Mr. Haas, of Bloomingdale, have traced the development of occupational therapy in those places, and similar pieces of research from other hospitals will be well worth while. More information is needed upon the cost of maintenance of occupational therapy departments and of individual crafts and industries. There are also many other questions upon which information is sought. For example: Is there a definite relationship between the recovery rate and occupational therapy? Is there a shortening of the period of care of recovered cases which may be traced directly to occupational therapy? Is there any one occupation which preëminently stimulates the patient's interest? Is there any relation between the stimulation of interest and the patient's psychosis? Or of his personality? Or previous training or experiences? It is from data obtained by such research that a more exact knowledge of the application of occupational therapy, as well as of human psychology, may be gained. The occupational therapy committee therefore hopes that at the next and subsequent meetings of the association there may be notable contributions upon this subject.

ANNUAL MEETING OF THE AMERICAN ASSOCIATION OF HOSPITAL SOCIAL WORKERS.—The next annual meeting of this Association will be held in Cleveland, Ohio, May 25 to June 2, 1926, with headquarters at the Hotel Winton.

The President of the Association is Mabel R. Wilson, Childrens Hospital, Boston, Mass. The Secretary is Lena R. Waters, 20 East Ontario St., Chicago, Ill.

Book Reviews.

Old and New Viewpoints in Psychology. By KNIGHT DUNLAP, Professor of Experimental Psychology in Johns Hopkins University; Formerly President of the American Psychological Association. (St. Louis: C. V. Mosby Co., 1925.)

A 163-paged gem for the reading of the psychiatrist who wishes to know "what it is all about." Professor Dunlap is a good writer, regardless of his overly polemic achievements, and presents his views in a manner to fix and hold the reader's interest. He has views which are of genuine value to the physician interested more in his patient than in the physiopathology, for example, of his patient's suprarenal gland. Dunlap's psychology is the psychology so well indicated by McDougall in saying—to quote our author—"Behaviorism is frequently presented to students as the only alternative to a certain other type of psychological theory commonly known as introspectionalism: whereas there is actually a third alternative, namely, *psychology*." Starting with a chapter entitled "Mental Measurements" in the preparation of which his coadjutors, Professor Bulford Johnson and Mr. Isaacs took part, the book might seem discouraging to the psychiatrist who is bored by the *mental test* situation. That would be an unfortunate impression. This is no dry (and perhaps stultified) scribbling about Alphas, Omegas, the American mental age, the result of maze experiments on one-eyed cirrhotics or what-not. It is a lucid exposition of the nature and field of *Individual Psychology* as distinguished from *General Psychology*. Not a person who has heard of a "mental test"—always excepting the one who *knows all about* them—need worry lest he waste the time given to reading this chapter: it contains common-sense statements of fact which he needs for his comfortable orientation. For certain ones, who, like the reviewer, have learned to shy at the problem of intelligence and its alleged measurers, the following is quoted: "Intelligence testing is the work of a specialist, and requires a specialist's training. The most serious danger in mental measurement today is the incompetent tester, without psychological background, who has picked up a superficial acquaintance with intelligence tests. . . . It is unfortunate that a great deal of misuse has been made of some results of the Army testing work. . . . Naive and reckless use of the correlation method has been the source of much and serious evil, and is something for which the blame lies entirely with persons who are supposed to be competent in the field of mental measurements."

"Intelligence testing is not the most important part of mental measurement."

Tests for capacity, means for the determination of aptitude in the learned professions, including the profession of being a student in a cultural college, development of measurements and technique in the industrial field, the problems of criminality and of immigration, the evaluation of emotional and moral tendencies; such are points in his discussion. Unfortunately, consideration is sometimes little more than nominal, but, as he points out, "Throughout the whole field of mental measurements, including that of intelligence testing, the vital need is for the promotion of research. Psychological research is as vital a necessity in individual psychology as in general psychology, and it is a pity that it cannot be more abundantly fostered."

Chapter II is entitled "Present Day Schools of Psychology." It will go far to elucidating the basis for polemic activities among current psychological writers. The psychiatrist, remembering Dunlap's early consideration and later emphatic repudiation of psychoanalysis, will be interested in the following: "The 'idea psychology' has not only given rise to the schools of introspectionalism and behaviorism, but also to a still more interesting and thriving movement which is popularly known as . . . psychoanalysis. This movement has caught the public attention very strongly for two reasons, first, because it deals much, and often crudely with sex problems; and second, because it offers a system of mental healing. . . . Even some psychologists, whose theories were strictly those of the idea philosophy, have been fascinated by the new formulation, which is in reality a logical development and expansion of that philosophy. . . . What Malebranche and Locke called an 'idea,' Freud and his followers, in so far as active force is attributed to these ideas have generally called 'wishes.' . . ."

The concept of symbolism as it occurs in the writings of the psychoanalysts is next considered by our authors. He gives reference to "Payne Knight, Thomas Inman, and many more eminent men, [who] long ago pointed out two things which may be true: first, that many, if not all, of our common art forms, and many of our common literary expressions were originally symbols with distinct and somewhat complicated meanings, which meanings have been largely lost; and second, that a great deal of this symbolism was sexual, that is, it referred to sexual situations or problems, or more frequently referred *through* these to philosophical or religious abstractions. From this point on, these older symbolists went rather wild, and reconstructed the lost meanings of some of the symbols by pure analogy. And Freud . . . took over also the easy method of analogical interpretation and applied it to the analysis of dreams." He thereafter quotes examples of "direct," "objective," interpretation of symbols occurring in a dream, made by one other than the dreamer—a procedure certainly unscientific in principle and classically "behavioristic" in implication. Nothing constructive is offered in this connection; Dunlap's is not yet a comprehensive psychology.

"The only common feature of psychoanalysis ['of widely varying schools and individual theories'] to-day is the insistence on the unconscious mind and its deadly power, and the corollary emphasis of the evil of repression. . . . The doctrine of the unconscious mind, like the doctrine of

God, belongs strictly to religion, and not to science. The psychoanalyst cannot get away from the doctrine of a mind which is a *thing*: a soul; something which has ideas as a tree has leaves, or as a dog has fleas. Psychology has abandoned these concepts, and deals only with a mind of a purely factual sort, namely, the series of acts which the individual *does*, which are popularly designated perceiving, thinking, and 'having' feelings. . . . These conscious activities constitute the *mind*, and the psychologist therefore has no interest in an alleged 'unconscious mind,' unless you mean by it merely physiological activities." The "merely physiological activities" which go to make up extra-conscious symbol activities, however, do not seem to the reviewer to be at all well covered by the author's recommended "perfectly unequivocal term *physiological*, although he admits that they have their effects on the conscious activities"; nor does the reviewer believe that Professor Dunlap can stimulate any of his physiologist colleagues to a research into their nature, habitat, and *raison d'être*. He continues, "any other 'unconscious mind' would be an equivalent to 'activities which aren't active,'" thereafter discussing the concepts of "capacity" or "potentiality." The upshot of the matter is "In so far as a capacity for thinking, feeling, or perceiving exists as a concrete fact, it is a disposition of the nervous system and nothing else of which science can take account. But we know little as yet concerning the nervous system, and the acquisition of greater information concerning it is one of the *least* important problems of psychology." [Italics ours.] In which statement perhaps a typographical error in the book, we concur (even knowing that Professor Dunlap is now working at an important investigation in neurophysiology); concur, we must add, not because neurophysiology is in itself unimportant, but because the extra-conscious and at best vaguely conscious relatively stable and enduring elements of mental phenomenology constitute themselves such a tremendously important problem of psychology and psychopathology, a problem for the solution of which we must bestir ourselves rather than await, for centuries, the explanation of the neuro-physiologist and physical-and colloidal-chemists.

"Repression" is his next topic. What he has to say about this is correct, if true. In other words, if the psychoanalysts hold "that repression is bad, and parents and teachers are urged to teach children not to repress," and there is nothing more to it, then "nothing could be more vicious or absurd than this doctrine. . . ." I do not know that I agree that "actual repression [in the sense Dunlap is supposed to intend] is the only salvation of man if civilization is to continue, and the ability to repress effectively is the greatest asset of human individual can have." Quite on the contrary, it seems as if this doctrine—for it is a doctrine—smacks of brain-mythology, and equally idealistic phantasies of the materialist epoch, mechanist period, to wit, *circa* A. D. 1910. Feeling that our several preconceptions will resolutely bar any "meeting of minds" on this issue, I will none the less suggest that an effort (mental or physiological, I care not which) towards a "well-planned, satisfying" life-plan and incidental policy, this including a mental (or physiological, if it suits the person) "work over" of "past

mistakes and illicit desires" so that one may profit by experience rather than load up on abortive and figuratively teratological "repressed" fragments; such an effort, I say, seems to promise much for civilization, and more for the man *under* civilization. Moreover, I cannot in any sense whatever agree with the implication of his statement that "in particular, the adolescent boy and girl need to have their attention drawn away from the surging desires of sex and turned in other directions," and I do not believe that Dunlap is at all competent to render us advice in the premises—even if he himself is an example of the success of the procedure—for I know many cases in which it has proved a signal and catastrophic failure. Knowing full well that the answer to this would refer either to "inherent defect of nervous apparatus," "eccentric potentialities," or equally overwhelming factors, I insist that no "drawing away of attention" as a hygienic or therapeutic method, can approximate the class of scientifically established technique—if, in fact, such method is anything more than a figure of speech. To leave this topic and abbreviate comment on the chapter, the reviewer will add that he cannot agree that "Freud and his disciples have contributed nothing of value to psychology . . ."; to paraphrase our author's words, it was rather discreditable to psychology to have been so far behind the progress of human thought that it could profit by this "mixture of psychology and superstition," as he calls it, and thereby become dynamic instead of idealistically static, a profit of which I will accuse even Professor Dunlap.

We now come to his discussion of "instinct." Here, in mentioning a "growing interest in the study of the prenatal life of the child, with a view to determining the course of development of its reaction tendencies," Professor Dunlap has an opportunity to give some credit to Professor Stanley Hall, and, through him, to certain other irritating stimuli. McDougall, who "has made in total as great a contribution to the science as any living psychologist, . . ." is mentioned particularly for his instinct theory, which "views the instinct, not as an abstraction, but as a concrete force, which expresses itself in bodily activity, but which cannot be defined in terms of reaction or bodily activities. . . . The instinct is definable only in terms of purposes, and purposes are apparently not due to physiological mechanisms, nor dependent on external stimulation, but are original activities of the soul." The "apparently" clause in this quotation is used not precisely for giving clarity to the subject matter; the word "soul" is used for purely polemic *purpose*. "The instinct psychology is, in effect, another manifestation of the same tendency which is exhibited in the old faculty psychology, and in the Freudian system: a tendency into which we all drop from time to time and which requires constant circumspection to keep out of. You notice a certain common characteristic in a group of phenomena; then you abstract that characteristic, give it a name, and explain the phenomena by saying they are manifestations of that abstraction you have named. . . . The instinct . . . rapidly became a venerated icon . . . until a stone the present writer [Dunlap] hurled at in 1919 precipitated a general disturbance, and the instinct became not only repudiated, but execrated. In plain

language, the instinct is now not only very generally rejected as an explanatory concept, but is, by some extremists, repudiated even as a useful abstraction, which is unfortunate." There follows a discussion of permissible usage of the term, "instinctive." The chapter terminates with, "At present, the psychologist needs to be somewhat skilled in speculation in order to avoid it efficiently." How even more true is this of psychopathology, and how nudely infantile would either discipline appear if utterly stripped of its speculation!

Chapter III is "Psychological Factors in Spiritualism," in the opening paragraph of which the author makes an excellent point; viz., that the alleged "great wave of spiritualism" is merely the result of "less hesitancy over admission of interest, and less fear of the results of confession of faith" in spiritualistic things. (In this chapter Professor Dunlap admits himself to the arcana of psychopathology, and thus to any so far apparently unjustified criticisms in this review.) "It is a striking thing that one can find in the past only an occasional psychologist mildly committed to spiritualism. . . ." McDougall is again mentioned on the score of being the lone experimental psychologist who accepts telepathy. There follows a fair discussion of evidence and its vicissitudes. Finally, we come upon, "In credulous belief, there is involved . . . a powerful drive of an emotional sort." We would ask concerning this drive—not in any defense of spiritism, but in the interest of autonomous psychology and psychopathology—if it be a physiological or an extra-conscious psychological factor. Dunlap "has marveled at the simplicity with which the desired interpretations are put upon the communications received" at spook seances; perhaps because he does not countenance anything as psychological which is exterior to "consciousness." He also believes that "many mediums are sincere, at least moderately sincere, and that even some of those who deliberately cheat and invent in their messages, really believe that a part of their communications come from a source outside of themselves." He appreciates, of course, the psychological importance of such an opinion. His exposition of the affair is intensely interesting—it "explains" many of those phenomena for which we find the concept of the unconscious rather useful. "The introduction of an explanation in terms of a mystic 'unconscious mind' is merely," he writes, "a device of those who do not understand the mechanisms of the mind, and hence cannot find a real explanation." The curious will find it all "really explained" in the chapter under review.

Chapter IV is entitled "The Psychology of the Comic": extensive and interesting treatment of *what* we laugh at, relatively little on *why* we laugh. One of the great problems of psychology—this matter of laughter—and happily, for a change, one not to be attacked by the fashionable "comparative" method which may culminate in speculations that sound so stiltedly "behavioristic," if not nonsensical.

Chapter V, "The Reading of Character from External Signs," is a delightful review of the activities of amateur psychologists. The mental measurement topic is further extended; I doubt if there be many readers who will not learn something from its perusal. The excellent paragraphs,

before the terminal utterance against "analysts," include: "It is therefore entirely possible that a scientific system of character measurement may some day be developed. Such a system would be based on physiological, not on anatomical signs, and would necessarily be the result of extensive and prolonged experimental work. . . . In the meantime, in the interests of psychology, both pure and applied, we must carry on an educational campaign against 'character analyses.'"

Physically, the book is entirely satisfying, well-made, neatly printed, well proofed, of good format. There is an index.

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An Introduction to Objective Psychopathology. By G. V. HAMILTON, M. D.,
Director of Psychobiological Research, Bureau of Social Hygiene, Inc.,
New York; Foreword by ROBERT M. YERKES, PH. D., LL. D., Professor
of Psychology, Yale University. (St. Louis: C. V. Mosby Co., 1925.)

The author of this book intends it to be "fairly intelligible to persons who are not psychologists" and seems to hope that he has produced something that will put the internist and general practitioner, among others, in comfortable rapport with psychopathology. Thus reassured, and with the fullest sympathy with such optimism, the psychiatrist should come to grips with this 330-page book for which Professor Yerkes has contributed a startling foreword. He hails "this little book as the *first chapter of a new and promising psychopathology*" [all italics herein are reviewer's] and regrets that he cannot quite hope that it "presages the dawn of a new day in mental medicine." "Hamilton's discoveries," he continues, "are undoubtedly of fundamental and far reaching importance," "though little known and less understood by psychologists and psychopathologists." "Such originality [as Hamilton's] . . . is rare, and almost as rare are those who can understand and appreciate departures from the 'sheep path.'" Yerkes admits frankly that he, himself, knows "the status of psychiatry and psychopathology and also their American personnel," so we may proceed without comment from this, his keynote for a "bigger and better" psychopathology to those data our response to which will classify us among the sheep and the goats.

"And then I changed my piping—
Singing how down the vale of Mænelaus
I pursued a maiden, and clasp'd a reed;
Gods and men, we are all deluded thus."

One hundred and seventy-three pages are devoted to brief reports of "Two Hundred Nervous Cases" culled from a survey of a "city of about 30,000 inhabitants. . . . a typical Mississippi Valley small city." They include all sorts of mental disorder, grave and trifling. There are flashes of wisdom and other things to be found in the discussion which completes most of the case reports. The therapeutic procedures suggested in these notes (including "riding with me into the country") should excite interest

enough to secure a reading for the second part of the book. There are recorded remarkable cases of failure; e. g., a seven year old "somewhat demented, unresponsive patient" the origin of whose "masturbation and unnaturally developed exhibitionism remained unaccounted for." The recorded successes, on the other hand, will certainly illuminate those who feel that one should have comprehensive data pertaining to a life-situation before he ventures to complicate it by suggestion, with or without prestige.

Chapter III, in which the survey findings are summarized, reports that 145 patients "seemed to owe their nervousness wholly or in part to maladaptive habits of response to personal problems and difficulties." Before discussing the author's views as to the origin of these habits, their intrinsic nature, and the procedures by which he seeks to eradicate them, it seems best to quote his table of diagnoses. The 145 cases mentioned are described as "Cases Presenting Pathological Types of Reaction to Stimulations Which Evoked Adjustments of the Organism as a Whole." The pathological types or reaction are enumerated as: (1) *Persistent Nonadjustive Affective Reaction* to (a) baffling physical discomforts and disabilities, (b) baffled effort to satisfy major cravings, (c) baffling impairment of advantage by personal agencies, (d) same—by impersonal agencies, (e) baffling economic difficulties, (f) baffling personal problems (unclassified), (g) fear-inciting stimulations; (2) *Indirect Reaction* to (a) sexual urges, (b) to masturbation, (c) to fear-inciting stimulations, (d) to inferiority (i. "compensatory manic," ii. "compensatory schizophrenic," iii. "compensatory alcoholic"); (3) *Complex Psychotic Indirect Reactions* of (a) dementia-precoc type, (b) paranoia type, and (c) acute-confusion type; (4) *Conditioned Fear Reactions*; (5) *Conditioned Inhibition of Exhibitionistic Urges*; (6) *Conditioned Overt Homosexuality*; (7) *Submissive Reactions to Inferiority*; and twelve others, including (15) *Direct Maladjustive Homosexual Jealousy Reactions*, (16) *Direct Maladjustive Reaction to Husband's Infidelity*; (17) ditto—to *Wife's Infidelity*; and (19) *Deliberate Malingering*. There were 133 patients who showed group (1), 13 in group (2). In fact, only 85 patients of the 145 showed any situation other than those included in his group (1). It thus appears that the "persistent nonadjustive affective reaction" is the great thing in psychopathology. This topic will recur in our treatment of Part II of the book.

This Chapter, besides summarizing the patients, includes an abstract of Dr. Hamilton's therapeutic methods. The patient is always "held to an orderly account of himself by being constantly reminded that the most important question . . . is this: 'To what things are you now responding inadequately, and how are you responding to them?'" This question, when changed to the past tense, should be constantly in his mind while he is giving an account of his previous history." Following his "general orientation as to the patient's previous history and his present condition," the doctor proposes to himself "three general questions, viz., (a) Is the patient reacting persistently, nonadjustively and affectively to baffling disadvantages of one sort or another? (b) Is he reacting directly to his personal problems or is he inhibiting direct responsiveness to them and disclosing, in consequence,

indirect reactions to such problems? (c) Does his present behavior, when correlated with known or suspected past experiences, suggest the presence of significant conditioned reactions?" "As soon as the patient's reactions have thus been typed *they are exposed to him as morbid things in the same objective way that one exposes to a tubercular patient the findings of the stethoscope, the microscope, the clinical thermometer and the x-ray.*" There lies the kernel of the "objective" technique.

As to the success of such an "innovation," one might expect more positive results with women than with men. The records show his rate of success with men as about 61.5 per cent; that with women, 66.3 per cent. On reviewing the ailments in the treatment of which Dr. Hamilton succeeded with male patients, much that is both interesting and entertaining comes to light. For that matter, statistical consideration of his frank failures shows a percentage of 19.6 of the women, and one of 30.7 with the man.

"A surprisingly large number of nervous patients sooner or later stop off at Santa Barbara. . . . Those who have come under my observation have usually discussed the more or less eminent psychopathologists whom they have consulted. I have thus come to know [like Yerkes!] something about the therapeutic methods of practically every American psychopathologist of repute. . . . It is apparent that each of these men has had patients who worshiped him and patients who damned him, and that none has lacked at least one individually fashioned weapon in his therapeutic armamentarium which all the rest might well covet." In view of this statement one expects searching criticism of what others have attempted to contribute to psychotherapeutic technique, and a greater number of choice weapons than have appeared in Dr. Hamilton's method so far outlined. The reader is not entirely disappointed. To speak in that delightful analogical figure of the psychoanalysts, he castrates them all, *and*, while there are no clear statements to such effect to be found in his book, he makes more or less practical use of much more psychopathological knowledge than is to be derived from his own formulations. The following extensive excerpts are included in order to indicate how the book approximates the promise of the foreword.

"The male puppy who rides another male puppy is thereby improving his chances of some day copulating with a female and thus doing his bit towards continuing the canine species; but it is contrary to the soundest precedents of the natural sciences to posit an unconscious psychical determination of such behavior." "Watson's plans for an unqualifiedly objective psychology which shall be adequate to the technologist's needs may be capable of ultimate fruition. On the other hand, the psychoanalysts may find—or scientific psychologists may find for them—a scientific way of demonstrating the psychical determination of all behavior, both normal and morbid. . . . I cannot escape the conviction that knowable and reportable psychical reactions—as contrasted with unverifiable inferable ones—have a special significance for psychopathology." Whence comes; "it seemed a merciful thing, in the circumstances, to spare the patient the discomfort involved in giving me an account of her earlier reactions to the father

situation, but it seemed so likely that the force of habit-inhibitions was to be traced to morbid responsiveness to the maleness of the father that . . . she was told, in effect, that practically all girls have flashes of incestuous responsiveness to the father, and that sometimes these are secondarily reacted to by an instinctive identification of all sexual responsiveness with incestuous responsiveness. . . . She recovered within a few weeks. . . ."

" . . . Symptomatic self-accusations, which are a natural part of . . . depression, often disclose long-standing difficulties of adjustment to his sexual urges, and these, however unimportant, are apt to be seized upon by the psychoanalyst as the major determinants of his psychosis."

" . . . He was asked to give me a fearless account of his childhood and adolescent experiences at the swimming hole frequented by the youngsters with whom he grew up: a generation ago the country swimming hole of which the poet writes so longingly was a *breeding place for all the nastiness of which original human nature is capable*. . . . He was . . . finally conditioned to react masochistically to the stimuli derived from the always intensely erotic atmosphere which prevailed at the swimming hole. . . . After he had attained a *fair degree of insight* into the nature of his psycho-neurosis he began to improve very rapidly, but there had developed an undesirable degree of dependence (the "fixation" of psychoanalysis [!]) upon me for directive advice, understanding, sympathy, etc., *which had to be explained to him*. . . ." In Case 79, "His sexual life, according to his account, was not especially significant. He had masturbated as a boy, and in later years used prostitutes and unvirtuous country girls whenever his sexual desires oppressed him. He hadn't married because . . . 'It was cheaper to pay a girl a little something now and then for a little fun.' The behavioristic mechanisms involved in his infrarational, nonadjustive habits of response to the need of a person like his father to complement him and to his baffled major cravings were explained to him. . . . Two or three free sessions started favorable adjustive trends, and he made a good recovery. . . ." Case 80: "His impatience with any effort to help him . . . and his arrogant assumption of superior wisdom and ability were inconsistent with . . . fact. . . . This attitude was clearly defensive, and reflected a *largely nonconscious adjustive movement towards compensating for a not very successfully inhibited sense of inferiority*. . . ." Case 101, in whose behalf "an effort was made to bring the patient to an understanding of the importance of stressing erotic values as little as possible." Case 102, concerning whom the author has "since regretted that she was permitted to make this confession prematurely. . . ." She masturbated. He recites that "Hysterical palsies, hysterical anorexia and vomiting and accompanying persistent grievance-reactions to petty infringements of personal advantage are often found to follow masturbation in a female who has hitherto successfully resisted direct responsiveness to all sexual stimuli for a long period of time, and who seems to have broken through the habitual inhibition and masturbated in a frenzy of erotic desire. Sometimes after a single masturbation, but more frequently after an autoerotic orgy lasting several days or even weeks, the patient finds her direct awareness-

reaction to her nasty behavior so painful that she makes a deliberate effort 'not to think about it.' This much [sic] one can obtain from the patient's reports of *her own awareness*, and without resort to any special technique; ordinary tact and diplomacy are the chief requirements. . . . " In case 103, "His history was too suggestive of masturbation to leave much doubt as to the cause of his nervousness," but limitation of space, we presume, prevented its inclusion. Case 104, who "came from a family of which nearly every member for two generations had been either tubercular or neurotic or both," was "as inaccessible as an old schizophrenic," but "during one of her very few accessible moments *she hinted* that masturbation had been a curse to her. . . ." Case 105 was a male who suffered nocturnal emissions as a "physical factor." Amongst other procedures used in Dr. Hamilton's attempt to salvage him, "the desirability of substituting non-erotic for erotic phantasies was explained to him. . . . The desirability of stressing other values than the sexual ones was explained. . . ." In the discussion of this case, there occurs: "The more serious cases of adult autoeroticism that have come under my observation have *uniformly impressed me* as having among their major determinants a tendency to stress the value of autoerotic satisfactions to such extent as to render *even quite adequate* ['objectively,' to Dr. Hamilton, of course] *sources* of normal heterosexual satisfaction insufficient to meet the urges of these patients. . . . I have knowledge of cases in which men with unusual opportunities for heterosexual gratification have similarly withdrawn themselves from responsiveness to real sexual relationships in order to indulge in the more satisfying constructions [behavioristic, needless to say] of their own imaginations." It is in the discussion of this case that Dr. Hamilton reviews "Fantazius Mallare," writing of Hecht's book: ". . . both the contents of the maniacally verbose dedication and the story itself reflect an abnormal accentuation of the sexual urge which is clearly responsible for a considerable mass of contemporary literature which is inspired by lay perusals of psychoanalytic literature." As he refers, elsewhere, to Hecht's "Gargoyles," one cannot but regret that "The Kingdom of Evil" seems to have missed him. He continues, "The remedy for adult autoeroticism, it seems to me, is to be sought in measures which are calculated to overcome the patient's habit of looking to sexual activities of whatever sort for his major satisfactions." Since the great innovations of Hamilton's views, whatever they may be, are alleged to be derived from comparative psychological studies, one pauses to wonder if the last quoted matter is purely objective. "One of my patients, who disclosed an entire willingness to cooperate with me, objected to the methods of the psychoanalysts as a kind of psychological rape, and said that my method, by its avoidance of specifically directive questioning, permitted the patient to rape herself in this sense." This book is replete with these remarkable thoughts: space restricts the consideration of Part I to a few more—a few pertaining to the important (in the reviewer's experience, not in Hamilton's) subject of homoerotic impulses. "Homosexuality in women is more easily dealt with, in my experience, than in men. In these cases *the physician ought to be*

able to disclose to the patient, by his own kindness and understanding, the attractiveness of the father-daughter relationship." "The so-called fixation of the patient upon the physician need mean nothing more embarrassing than that he has acquired for her the reactive value of a male parent. Hand-holding, back-patting and still more erotically tinged kinds of 'petting' only tend to change the father-physician into the self-seeking lover, and, in my opinion, ought never to be resorted to unless the physician wishes to marry his patient." (Page 154.) Of patient no. 111, who suffered "hystero-epileptic seizures," he writes, "In time the friend became a sexual object for the patient, *but here*, as in the father-relationship, *the patient inhibited all direct psychical reaction* to the urges kindled by the friend excepting an allowable sense of affection for a good friend": one might wonder from what "objective" criteria he derived this. The wonder approximates an emotion of marvel when one reads, "Repeated examination of both girls convinced me that *neither was clearly conscious of the erotic element in their relationship*." Equally mysterious as to its "objective" origin is his statement that "A seizure meant a night in the friend's arms."

I have sought but I seek it vainly that "rare originality" in the first section of the book. It is in Part II, which is entitled "Principles of Objective Psychopathology," there if anywhere, that it must reside. Chapter IV, the Introduction, includes comments on the difficulties of the internist when confronted with psychological propositions, which, "as he has been taught to regard them, are for the most part only verifiable in another and somewhat esoteric dimensionality." There follows an account of Dr. Hamilton's psychopathological "coming of age." Chapter V is entitled "The Foundations of Psychopathology." Here, we learn—which was not previously to be suspected—that "This book is exclusively concerned with the kinds of nervousness that . . . do not require institutional management"; that is perhaps what has ailed our search, so far. The book "stresses the importance of behaviorism as a foundation for psychopathology because . . . the behaviorist regards the adjustive responses of the organism as a whole to its environment as reflecting the possession of physiological properties which belong in the same category with those upon which the organism is dependent for its intrasomatic adjustments (*e. g.*, metabolism, resistance to infection)." The greater familiarity of these terms certainly exercises a wonderful fascination. While only a bio-chemist or physiologist has a clue to the astounding complexity of the phenomena of which Dr. Hamilton writes so glibly, many of his readers will, no doubt, feel much more at home than would be the case were they reading a simple and logical discussion of the psychobiological functioning of symbols. Such is the illusion of the common-place. "The vastly . . . complex nature of human behavioristic functions is matched, *of course*, by an equally complex neural morphology. . . ." Another "objective" datum, doubtless. James, Lange, Sherrington, Cannon—names to conjure with—receive honorary mention. "Until Freud proclaimed the importance of unconsciously held 'desires' and proposed methods for their disclosures we psychopathologists were a futile lot. . . . Psychologists were equally futile. . . ." This is followed by announce-

ment that the succeeding chapters will show how the author has perfected the matter so that it is "possible to abandon unverifiable psychomorphic interpretations of nervousness without thereby sacrificing anything of value that psychoanalysis has to offer." That is about as clearly formulated a statement of his inspiring ideal as the reviewer has encountered in this delightfully inconsistent book.

Chapter VI rehearses neural morphology, neural physiology, and endocrinology, all in nine and one-half pages.

Chapter VII is "Comparative Studies of Reactions to Baffling Disadvantages." In it, sundry well-known matters of human behavior are given a luridly verbose reinterpretation in "objective" language; one is to understand that this results from revolutionary discoveries in comparative psychology. Chapter VIII is entitled "Habit Formation." "One's ability to effect a cure in a given case of nervousness is often contained in the possibility of enabling the patient to develop habits of rational responsiveness to situations which have previously elicited infrarational, more primitive and—by reason of their affective components—pathological reactions." This conception of "objective" rational adjustments as normal, and "affective" responses as abnormal comes I know not whence. Hamilton accepts "simultaneous response in the glandular system" as "corresponding in part at least to the affective values of the psychologists and psychopathologists." What else he accepts in this connection has not appeared in the course of our hasty survey of this revised James-Lange hypothesis. The following inversion of values is an instance of the poor reward our author gives to those from whom are derived many of his none too explicitly formulated or consistently applied propositions: "Kempf's suggestive textbook of psychopathology gives recognition to the value of the principle of the conditioned reaction in medicine, and contains an ingenious theory of vegetative neurology, but he holds fast to psychomorphic interpretations which are of the very kind that long ago so dissatisfied comparative psychologists that they abandoned the general standpoint from which Freud and his followers proceed."

"We regard the activities of the organism as most directly attributable to the functioning of *physiological properties* . . . designated reactive tendencies. . . ." "Practically all of my clinical as well as my field and laboratory investigations have been directed towards the isolation of these responsive properties in the behavior of human and infrahuman mammals. McDougall's innate conative tendencies . . . have a somewhat similar connotation. . . ." "All types of mammalian reaction—whether these be psychical or nonpsychical, behavioristic or intrasomatic—reflect the functional activity of organic properties (reactive tendencies) which can be most simply and fruitfully dealt with as *physiological quanta*." This word, quantum, which one can picture reverberating in the ventricles of a "pure objectivist," has a "connotation" in the physical sciences which is profaned by any such use as Hamilton makes of it. One must not be misled into supposing that he has elaborated any quantum theory of physiological and psychological relations; far from it. He likes the word, that is all: *vide*, "Over-determination, censorship, complex, repression, sublimation—these

are quanta to which" his protege the internist "cannot gain orientation. . . ." The reviewer's ire at the misuse of *quantum* arises from the possibility that something may come from the cautious extension of this concept of energetics into the realm of mind. To resume; on page 233 begins the harvest of fruit of the author's above mentioned pursuit. ". . . . It is known to everybody that man is so organized that when an external agency tears or burns his skin, he experiences pain (psychical activity) and withdraws himself from the injuring agency (behavior). . . . It is a basic property of the human organism to react to destructive stimuli by *experiencing* pain and making appropriate withdrawal movements. Other types of responsive properties are not so easily recognized. . . . Psychopathologists seem to have overlooked the possibility that such pathological responses as those of the masturbating spinster may have a scientific knowability and manageable physiological determination fundamentally like that to which we ascribe the abrupt movements of withdrawal and the reported pain of a patient whose abscess is being cut. . . ." After this important formulation, there follows a fine demonstration of "omnipotence of thought" in his showing of this alleged "fundamental likeness." Then comes, "comparative studies of human and infrahuman primate behavior have made possible the *explicit identification* of a primary responsive property which satisfactorily accounts for the 'unconsciously determined' symptoms of the masturbator who is very hypochondriacal and who seeks and cherishes innumerable petty grievances. . . . The masturbating spinster: her reactions and those of an outbluffed monkey are capable of the same *general teleological interpretation*." And here it is: "Direct psychical and overt reaction to a *weak yielding* to a *degrading impulse* would not only be painful, but would render it difficult for a mature, dignified gentlewoman to *maintain her status as a person to be taken seriously and respectfully* by her fellows, hence the value of the indirect reaction. Likewise, direct reaction to the situation by a monkey who has just been outbluffed would seriously interfere with his *status in the tribe as a dominant male*—a consideration which enables us [sic] to ascribe a conservative value to his indirect reactions." In other words, we avoid the distressing "psychomorphic" formulation of our necessarily somewhat subjective psychopathology by formulating it in the "biomorphic" mode, thus making our psychopathology "objective." As the monkey (or a paramecium) does not report any data pointing to a personal need for self-esteem, we can be nothing but accursed subjectivists if we deal with any such alleged entity in human psychology; we must couch the situation in polysyllabic behaviorist jargon if we are to avoid this profound inferiority.

The pursuit of "responsive properties" lead Hamilton to the following not entirely vacant discoveries concerning mammalian response to baffling disadvantages. When he placed an animal in a space provided with three blocked and one available means of escape, he found that, in many cases, there occurred (1) *persistent repetition of nonadjustive activities*—attempts at an exit already "found" unsuccessful. "The factor most conducive to the exhibition of persistent repetition of nonadjustive activity was any

concurrent emotional response, whether this was due to the baffling as such or to adventitious stimuli": (2) "A compound reaction which includes alternating variation of adjustive effort and persistent repetition of a non-adjustive effort." This passes over into psychopathology as the principle that "Such a patient is thus more wisely varying her adjustive efforts only part of the time, and . . . there is an almost rhythmic recrudescence of the nonadjustive *affective* response. . . ." I suppose that we are to understand that the "wise varying of adjustive efforts" is non-affective: (3) "The tendency to stereotype a systematic mode of searching for an escape from a disadvantage without eliminating *obviously* nonadjustive activities"—this "has no very great clinical importance . . .": (4) "Infrarational trial-and-error reactions to baffling disadvantage." He discovered that "older human subjects" showed less infrarationality than did children and other mammalia (the horse was not included). "We regard ourselves as preponderatingly rational in our behavior when, as a matter of fact, we are usually only *intelligent*, i. e., *we usually just try, try again* as do the animals . . .": (5) "Reactions determined by *rational elaboration of experience*." Here, the biomorphic language seems to have necessarily come a bad cropper. Perhaps this string of conclusions is of more promise to psychopathology than was the "Problem of Mental Reaction-types, Mental Causes, and Diseases" (1908) and the subsequent contributions in this connection by Dr. Adolf Meyer—but I doubt it.

Chapter IX is "The Relation of Inhibition of Responsiveness to Indirect Responsiveness." It opens with another fruit of his quest—The Principle of Selectivity of Adjustive Function, which "implies possession of some sort of capacity for inhibiting dysteleological adjustive impulses. . . ." Then comes "A General Inhibitive Tendency in Mammalians." This is followed by "The tendency to react indirectly to stimuli, direct responsiveness to which is habitually inhibited: when an animal is unable to acquire relatively complete unresponsiveness to a stimulus, direct response to which is disadvantageous, it tends to react indirectly and, usually dysteleologically, to the stimulus. This is a behavioristic formulation of Freud's most important finding in psychopathology. . . ." ". . . Even Dunlap, who has shown an inflexible hostility to psychoanalysis, seems to have missed" Hamilton's discovery that it is possible that "it may be the primary stimulus which remains dynamic for behavior" in such conditions, for example, as those described by the psychoanalysts as "repressed." In other words, having in mind the fact that Dr. Hamilton *does not* refer to symbol dynamics, and keeping to the text, if one is disgusted by the unblushing nastiness of a patient who masturbates, yet feels constrained by economic stimuli to appear suave and omniscient, his later reaction in the premises is "perhaps" not due to the indirect expression of the inhibited impulse to reveal to the culprit the baseness of his behavior, but to the "dynamic remaining" of the patient. The text seems to indicate that this is a refurbishment of the doctrine of "wish-fulfillment." ". . . Every psychopathologist knows that a boy who has masturbated during the night or early morning tends to 'pick a fuss' with some member of the family at the breakfast table,

to find fault with his food, or to complain of vague physical discomforts. A clinical generalization is not difficult to arrive at without resorting to forced and unverifiable psychomorphic interpretations: [the interested will find the generalization on page 281]. . . . A great variety of stimulations which are reacted to indirectly in the form of nervous symptoms will be identified by the clinician who maintains his orientation to a few relevant facts and interpretations of neural morphology, neural physiology, and behavior, and who is not frightened into a denial of his obligation to the nervous patient by the elaborate pretensions of a psychomorphic psychopathology." Witness, on the next page, "a consciously held desire of which the patient is ashamed. . . ." Hamilton has not yet, I fear, completed the transit in his neural apparatus, from the masturbatory activities of his simian objects and their "nonaffective, rational adjustment" thereto to the salvage of his own affective infrarational indirect responsiveness to those problems of genetic psychology which are the phenomena of autoerotic behavior and thinking.

Chapter X, under the title "Unsatisfied Major Cravings" gives some credit to Thorndike. As our author, in a belated effort "to avoid awkwardness of terminology," admits "craving" and "satisfaction" to his learned pages, his readability "picks up," remarkably. The gist of this chapter, however, appears in italics, as "my present formulation. . . . If any of the basic needs of a primate remain unsatisfied for a considerable period of time, appropriate endogenous stimuli are apt recurrently to dominate the organism's adjustive functions. At such times striped-muscle and visceral innervation [presumably without 'pathological' affective concomitants] tend to be persistently set for the quest and utilization of whatever may be required to satisfy the unsatisfied need."

Chapter XI is "Reaction to Inferiority." Adler, Kempf, and Thorndike are mentioned. "Kempf has amended Adler's theory of organic inferiority in the interests of a more thoroughgoing psychomorphic interpretation of abnormal behavior. . . . Kempf's observations and interpretations are those of a psychiatrist, and are therefore largely based upon studies of a class of patients whose adjustment to the fear of the consequences of inferiority are apt to be extreme and eccentric. My own views of the matter have been determined by comparative studies of mammalian adjustments to inferiority, including those of the nervous patient. Kempf does not refer to the submissive type of maladjustment to inferiority. . . ." This should be a pleasant stimulus to those who recall that Kempf and Hamilton worked, very severally, at about the same time, on the behavior of monkeys—Kempf, at least, with valuable results (and the nearest approach to a real contribution which the reviewer has discovered in this book is that based on the experiments in "baffling disadvantage"). Hamilton's contribution in this chapter is quite readable—he has not yet found his metier in the "objective" nomenclature of inferiority.

Chapter XII, "Sexual Behavior" deserves extensive notice. Aside from the importance of "sexual responsiveness" in peace-times living, our interest is further whetted by the fact that Hamilton, in classifying his survey

patients, listed but 22 of the group of 145 under headings referring rather directly to sexual situations, although his interest as reflected in the book, has never seemed to wander so very far from "masturbation." There are some thoughts in this essentially readable chapter which arrest the attention. Writing of "some sort of normal craving" satisfied by "stimuli derived from sucking movements of the mouth and from contact with the object sucked," he remarks: "We know, of course, that its indulgence in the form of ardent kissing by sexually mature human mates or potential mates has a definite biologic value for the reproduction of the species." It would appear that "oral erotic" phenomena are not of great interest to our author. He writes of them under the heading, "Autoerotism (Not Including Masturbation)." However, he includes: "Among harlots the enormous overvaluation [financial?] of sexual satisfactions and an apparent desire to seek variety of sexual stimulation seem to lead to this perversion in many cases." The same situation "seems also" to account for "the male's submission to the woman as the aggressor and the development of the habit of using his tongue to gratify the female or another male. . . ." He dismisses this phase of his subject with "The prognosis of these cases is not necessarily bad, although I have known two cases—women—in whom serious paranoid developments followed *enlightenment* as to the horror in which this type of perversion is held by most normal people."

"Anal Eroticism," on the other hand, has a section to itself. It is remarkable. "Narcissism" heads the next section. There follow "Exhibitionism," "Curiosity as to the Sexual Structures and Behavior of Others," "Incestuous, Matricidal and Patricidal Tendencies"—here, as elsewhere, the urge to resymbolize psychoanalysis interferes with original contribution. Section 9 is "Homosexual Behavior." Its first sentence is, "It is significant for an explanation of adult homosexuality that this inversion of the *most important of all the human instincts* is more commonly encountered among men than among women, and that infrahuman primate homosexual plays are almost exclusively confined to the males. . . ." The feebleness of this section excites pity; witness, "the decent, normal male adult almost reflexly inhibits his responsiveness to any sexual stimuli which may not *properly* incite him to sexual behavior; but when, for any reason, such as unduly prolonged continence or an *accession of altruistic concern* for a boy with whom he has consequent physical contacts, such a male's inhibitions of sexual responsiveness to boys is retarded, he is apt to have a *moment of mental discomfort*. A well-balanced, self-possessed man who is *sure of his inhibitions* will shrug his shoulders in philosophic acceptance of an inescapable tendency of his own make-up, and rest content with the fact that the necessary inhibitions assert themselves so promptly and effectively that no embarrassing overt behavior ensues"—the objective psychopathology. It is almost gratifying to find that our author does "not feel qualified to offer a behavioristic explanation of homosexuality in women. . . ." Section 10 is "Fetichistic Behavior"—"the tendency of mammals in general to react to a part of a stimulating object as to the whole . . .," which seems strangely reminiscent of the doctrine of the "engram." Section 11—"Masochistic and Sadistic Behavior"; interesting observations on monkeys,

with added remarks on the author's conviction that "pure love," in quotation marks, "of girl for boy and boy for girl . . ." has a "normal occurrence" among "relatively uncorrupted descendants of pioneer Scotch, Scotch-Irish, English and German settlers in the country of my survey." (The reviewer wonders if there were no relatively uncorrupted descendants of Irish settlers in that section, but he must, of course, remain impersonal.) There are three pages of generalizations under this heading. Section 12 (the end) is "Masturbation." The story is somewhat as follows: In nearly nine years of study of infrahuman primate behavior, Dr. Hamilton "did not once observe a normal, free monkey in the act of masturbation. Captive monkeys of both sexes are apt to masturbate. . . ." He does not refer to the frequency, among them, of the "grievance-reaction," etc. "Boys who have not been taught to masturbate by other persons, who have been taught to retract and cleanse the prepuce regularly, who have been given full and tactful answers to their childish questions as to how babies come into the world, who are encouraged to believe that they will find no serious obstacles in the way of early mating, and who have reactive equipment of average adequacy and balance, *do not, in my experience, tend to masturbate.*" The reviewer cannot escape envy of the source of this "objective" data. One would look to an autogenous source, but the next paragraph suggests that Dr. Hamilton has not had an opportunity to observe infants. This section ends with a sentence with which, I am sure, we can all agree: "If the uprising generation is told that thriftily saving money or defending the property rights of others or inventing new things or attacking evil customs are mere sublimations of psychical energies which were initially directed toward obtaining the satisfactions derived from anal eroticism, imaginary father-castrations, incestuous activities, demonstrations of sexual virility and finally achieved heterosexual successes they will have, it seems to me, a very poor philosophic substitute for a truly biologic outlook on life."

Having a deep sympathy with our author's statement concerning the sending of incipient mental patients to institutions where the "medical officers knew only the custodial part of the therapeutics of neuropsychiatry"—and wishing again and again that "the internist who sees the dementia precox patient in time to prevent a hopeless disintegration of adjustive functions" might realize and "adjust" to his obligations of bringing such patients under the care of competent neuropsychiatrists, the reviewer cannot but feel that there is still a remarkably large field for "subjective" psychopathology, on the one hand, and that Dr. Hamilton has been remiss in denying the internist an insight into diagnostic criteria. Our author has neglected to lay stress on the differentiation of the patient who can be benefited by his "objective technique" in contradistinction to the one who requires thoroughgoing psychotherapy. His cases do not make clear this distinction, for most of his failures are charged off against moral turpitude or other extra-scientific ethical factors. The internist who attempts to apply moral scruples and popular value-superstitions in his therapy will be of no more assistance to the incipient "dementia precox" patient than were the parents and friends. If the "objective psychopathology" can be rid of bumptious assumptions of Puritanic ethical absolutism, it will per-

haps be admissible to the anteroom of science, along with most other psychologies and psychopathologies. In its present form, it is not even a quasi-philosophy, for it is shot through with fallacies of various kinds—confused categories, non sequitur, *petitio principii*, and so forth. As a literary contribution to the field of critical writings, it adds nothing to the anti-Freudian collection. As an epitome of current psychopathology and psychotherapy, it is of little value; the author is either remarkably misinformed or peculiarly blind in interpreting the achievements of the very few to whom he refers.

The book is recommended for the attention of the neuropsychiatrist. No one of the problems of human behavior is in the condition of its final formulation. It is his duty to overlook no assistance to a clarification of the work in which he is engaged. By training, he should be prepared to separate personal warp from generally valid thought. Subjected to that technique, Hamilton's monograph is by no means without its value. The conclusions from his studies in comparative psychology may help many.

Holding no special brief for psychoanalysis, urging at all times the evolution of psychopathology as a coherent and exhaustive inquiry into behavior and thinking—without dogma or doctrine—the reviewer cannot but regret, firstly, that Dr. Hamilton felt that he was making a great contribution by terminological refurbishing of Freud's ideas, and, secondly, that the attempt, if it must be made, was not preceded by a more personal acquaintance with those ideas. While a personal "analysis" is not a *sine qua non* to the scientific study of normal and abnormal psychology, and it may work to limit as well as to extend personal perspective, it would have, in Hamilton's case, eliminated some of his unwitting distortion of results. Genius may be a delicate product which is fed by the energies arising in great personal difficulties—as such, a thing endangered by any rigidly formulated generalizations—but genius in psychopathology seems to classify pretty well within two or three categories in no one of which our author finds a place.

An interpretation, whether it be called objective or subjective, scientific or metaphysical, owes its inferential value to others, to the revealed character, personal and methodological, of the investigator from whom it proceeds. Interpretation in psychopathology passes from the personal opinion category under two or three sets of circumstance, only: When the work reflects a great and consciously comprehended interest in the particular deviations which make up the research problem, this coupled with observational acumen and intellectual keenness—even if of the "intuitionist" type; and secondly, when a cold skeptical attitude towards all that has gone before is coupled with the same "faculties," the whole inflamed by the interests of the pioneer. A combination would be most promising. Let us hope that the book under review may stimulate something of that kind into timely appearance.

The book is excellently made, well printed, altogether satisfactory from a physical standpoint. There is a glossary and a quite fair index.

HARRY STACK SULLIVAN, M. D.,
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Fortschritte der Sexualwissenschaft und Psychoanalyse. (Leipsic and Vienna: Franz Deutike, Vol. 1, 1924.)

This year book is the first number of a publication presenting contributions of the "Association of Independent Medical Analysts." In contrast to the publications of the orthodox Freudian School, which Stekel comments now deal almost exclusively with metaphysical and metapsychic aspects of psychoanalysis, it is intended to make this new year book one largely devoted to clinical presentations.

The volume contains 17 papers written by Stekel and members of his school. The greater portion refers to epilepsy, although collectively it is not a symposium. Several of the articles state the essential departures of Stekel's analytic technic from the orthodox Freudian, namely, that his is an active method developed through the analysis of the dream-life of the patient in order to more quickly see into the soul-life, and that the intuition of the analyst enhances the rapidity of the process. Stekel does not, however, disparage "free-association" and the ideas of the patient.

In the "Polyphony of Thought," Stekel likens the thought-process to a musical composition made up of the superficial over-tone, the middle tones and the counter-point. Most people think on the surface and crystallize thoughts into words in a superficial way. This surface material is, therefore, manifest in the over-tone or melody. What is most important is that which lies submerged in the pattern, namely, the middle parts and the counterpoint, or what has to be analyzed in a composition. The whole is a harmony. In the parathetic, however, it is a disharmony and it is the task of the analyst to reharmonize after psychosynthetic measures. The analogy is cleverly and artistically presented. The idea of "thoughts without words" being nascent states of words out of which language and thought expression are built with the affective components giving rise to complexes, resistances, and repressions, is new clothing for old ideas though it may simplify matters to think in terms of musical theory. As an introduction to his next paper, he states one should listen for the tones of the middle parts and the counterpoint in epilepsy and allied states.

In the succeeding study entitled "Epileptic Symptom-Complex and its Management," the style is that of the same author in his "Peculiarities of Behavior," written as convincingly and seriously, and with the usual evidence of case-analyses which for the most part are presented in the next paper by his pupil, Graven.

Stekel's presentation of his reasons for this work contains a thorough and complete discussion of epilepsy and the problems of differential diagnosis and research in this field. Those epileptics which have been cured or benefited by him belong to those unconditioned organically, but are not essential epileptics. He states explicitly that the article deals only with the epileptic-symptom-complex. After a review of the various reactions of epileptic character or personality, he regards these as half interpretative if not entirely descriptive and criticizes and extends Piece Clarke's observations. He thus finds that by deep analysis in contrast to Clarke's "superficial interviews," there are seven additional classes of epileptic seizures besides Clarke's,

"Mutterleibs phantasie." These types differ from one another in the unconscious mechanisms lying at the source of the attack. An outline for routine therapy is presented. Chiefly this is the withdrawal of drugs. The differential diagnosis of epilepsies inorganically conditioned is possible through psychoanalysis which in consequence turns the patient from regression to progressive social life.

Graven's 10 analyzed cases apparently afford this young analyst genuine enthusiasm both for the psychoanalysis of epileptics and for his teacher's methods. Their conceptions of epileptic dementia is like that of schizophrenic dementia, namely, that the epileptic progressively introverts into a regression on a par with schizophrenic autism.

The succeeding three papers deal with single cases of epilepsy analyzed by their authors, Heberer, Wittels, and Sonnenschein, respectively, and with gratifying results.

Stekel follows these with the analysis of a "Remarkable Disturbance of Sleep" supposed to have been caused by Kidney-Colic until the analysis brought out its relation to erection of the penis and urine-pressure.

Missriegler's paper concerning the "Psychogenesis of Narcolepsy" emphasizes that this condition is a parapathy (1), differing in length from normal sleep and (2) similar to catalepsy as a sequela to, or concurrent with an organic illness. The phenomenon of motor-inhibition prevents the carrying out of the phantasy into reality.

Wittels next presents a case of sleeping-sickness with personality change cured by analysis; and he concludes that the last word over the question of Parkinsonismus has not been said.

The analysis of a cataleptic by Stekel is "something never before attempted." He asserts that the akinesia of the cataleptic is the direct opposite of the hyperkinesia of the epileptic. This difference is based upon unconsciousness motives.

In succession are Gerter's "Contribution to the Psychology of Morphinism" with an analytic study and Gutheil's long details of a "Case of Impotency upon a Counting-Compulsive Basis," the difficult mathematics of which was solved by his teacher, Stekel.

"A Castrated Bridegroom" is the title of Wittels' next paper. This analysis is cited as an example of the success of Stekel's rapid methods versus Freud's slow one.

Tremmel makes a contribution to the technic of psychoanalysis in his short paper on the "Complex-Stimulation Method."

Kaplan's "Pieces of an Analysis of a Parapathy upon Narcissistic Foundations" is cited with the editor's note, "We herewith give to a real adherent of the Freudian School the opportunity to express his opinions concerning a parapatric illness. It submits interesting inferences if one wishes to compare the methods of the two schools."

"Something about Religious Feeling and Narcissism from the Psychosynthetic Viewpoint" by Emanuel of Geijerstam of Sweden is a psycho-philosophical treatise upon certain aspects of the unconscious in opposition to Freud's theories that this region of the mind is infantile and inferior.

Though it does have a primitive thought character, it contains the essence of a dogma-free religion or a life-belief which the neurotic has missed. The sexual objective in dreams is a life-task, for in the nature of the Great Love, there is a blending of the "spiritual-intellectual" with the "sensual-physical."

The paper is published for purposes of an open forum that hearkens back to the late controversies between Freud and his earlier pupils.

The last article is written by Stekel in Memoriam Herbert Silberer.

R. R. DIETERLE.

Die Unehliche Mutterschaft (Illegitimate Motherhood). By DR. EGON WEINZIERL. 79 pp. (Berlin and Vienna: Urban & Schwarzenburg, 1925.)

Whatever deals with human behavior and its underlying motives must be of interest to the psychiatrist. It is largely from this aspect that one may call attention in a psychiatric journal to a contribution which is of more direct concern to the gynecologist, hygienist and sociologist.

This contribution is a study of the mental attitude of women patients who seek relief from their pregnancy and in particular the problem of abortion in its personal and sociologic relations.

Impressed by the increasing frequency with which these problems are occurring in recent years, and especially in married women, the author endeavored to ascertain the factors that are producing this. On the basis of a statistical study of 500 women coming to a large gynecologic clinic he discusses the motives that impell women to terminate their pregnancy, or have restrained them from this before coming to the hospital. In the former instance he finds the most frequent motives to be feelings of shame and inability to handle their problems, through family or social and economic difficulties. In recent years the post war situation has seemed to be a factor. The many women who have wished to be relieved but have been deterred from this he finds have been largely influenced by a knowledge of the serious effects of abortion, and by a moral revulsion towards the act. A considerable number of women, particularly those illegitimately pregnant, were of sub-normal intelligence or lacked the moral attitude of the average personality. The legal penalties relating to abortions seemed to have little influence in the majority of instances.

As a remedy for the situation he suggests a program which would be directed towards raising the general mental level and moral standards of the population. As the problem is one that effects the state and race he would urge the development of a greater interest on the part of the state towards prenatal care of the pregnant woman and a concern for the after care of the child and mother. It would be desirable to establish some form of legal tribunal which would have charge of the complex medical and social problems that are involved in the situation of the pregnant woman.

The point of view from which this study is made is an interesting illustration of how psychiatric thought is gaining a place in the solution of many medical and social problems.

A. M. BARRETT.

In Memoriam.

MARCUS B. HEYMAN, M. D.

Dr. Marcus B. Heyman, superintendent of the Manhattan State Hospital, died suddenly at his home on Ward's Island, New York City, on the afternoon of October 7, 1925.

Dr. Heyman had been in his usual health until about four or five days prior to his death. At that time he complained of mild indigestion but had been attending to his work and was as active and as much interested as ever in the welfare of the hospital, in fact, he had recently initiated several new hospital projects which required close oversight. On the morning of the 7th, Dr. Heyman was in his office and in company with Dr. Furman, first assistant physician, went to his home for luncheon at about 1.00 p. m. At his house he complained of indigestion and took a simple digestive remedy. He ate a light luncheon and soon afterward lay down for his usual noonday nap. He had been in the habit of resting after lunch since his illness of a year ago. He seemed to be feeling about as usual as he chatted cheerfully with Mrs. Heyman during the luncheon and manifested no serious symptoms when he retired. At about 2.20, Mrs. Heyman looked in his room to see how he was resting and discovered that he had passed away.

The funeral was held at his house at the hospital at 11 a. m., Saturday, October 10, and was attended by the State Hospital Commissioners, members of the Board of Managers of the hospital, the hospital staff and many distinguished friends from New York City and elsewhere. Nearly 100 floral tributes testified to the esteem and affection in which the Doctor was held. The interment took place at Bay Shore, L. I. The funeral cortege was escorted by motorcycle policemen to the city line and by State troopers from the city line to the cemetery. The services at the grave were attended by a large gathering from Central Islip State Hospital where Dr. Heyman had previously served as first assistant physician. The burial rites were conducted by the Masonic Lodge of Islip.

Dr. Heyman was born at Chester, S. C., March 6, 1867. He received his preliminary education in the public schools of Chester and the University of South Carolina. After graduation from the latter institution, he came to New York City and took a course in the Bellevue Hospital Medical School from which he graduated with the degree of Doctor of Medicine in March, 1890. The month following his graduation he received an appointment as assistant physician in the New York City Asylum for the Insane and continued in the service of the institution when it became the Manhattan State Hospital in 1896. In 1901 he was appointed first assistant physician in the Central Islip State Hospital and in 1912 was promoted to the position of assistant superintendent. On May 1, 1917, he was appointed medical inspector by the State Hospital Commission and after serving in this position one month was transferred to the position of superintendent of the Manhattan State Hospital. He continued in the latter position up to the time of his death.

During a period of over 35 years, Dr. Heyman's life was devoted entirely to the care of patients with mental disease. He early gave evidence of unusual executive ability. This served him well in the difficult position of first assistant physician and assistant superintendent in the Central Islip State Hospital, where he served 16 years, and won for him the superintendency of the largest hospital for mental disease in the whole world. During the eight years of Dr. Heyman's administration, the Manhattan State Hospital had been greatly improved both in its physical plant and its medical efficiency. An outstanding accomplishment was the establishment in 1922 of a diagnostic clinic. This has greatly aided the proper examination and treatment of patients. The successful operation of this clinic has led to its being adopted in many other large hospitals.

Dr. Heyman had a broad interest in the field of medicine and was a member of many medical associations among which was the New York Academy of Medicine, Associated Physicians of Long Island, New York Neurological Society, Society of Medical Jurisprudence, American Public Health Association, American Psychiatric Association and the New York State Medical Society. He was vice-president of the last named organization in 1917 and 1918. At the time of his death he was chairman of the Committee

on Arrangements for the annual meeting of the American Psychiatric Association, which is to be held in New York City next June.

Dr. Heyman was a friendly man and had a host of friends both within and without the State hospital service. He was especially beloved by the patients and officers and employees of the Manhattan and Central Islip hospitals.

His home life was exceptionally beautiful. He was intensely devoted to his wife and children and together they constituted a most charming family. His death to them is an immeasurable bereavement.

Governor Smith on being told of Dr. Heyman's death gave to the press the following fitting tribute:

I cannot escape the thought that this man gave his life to the State of New York. There is no more difficult public position in this State than superintendent of Manhattan State Hospital. He was untiring in his efforts to give to the mentally sick the best attention possible. The hospital system of the State will miss him. The State itself loses a good citizen and a faithful and devoted public servant. Sincere expressions of sympathy go to the family from the people of the State of New York.

At a meeting in New York City, October 8, 1925, the State Hospital Commission adopted resolutions relative to Dr. Heyman, as follows:

WHEREAS: The State Hospital Commission has learned with profound regret of the sudden death of Dr. Marcus B. Heyman, superintendent of Manhattan State Hospital, at his home on Ward's Island on Wednesday, October 7, 1925, and

WHEREAS: In Dr. Heyman's death the Commission feels that the State of New York and particularly the State Hospital System has sustained the loss of an official of high professional standing and marked executive ability and

WHEREAS: The Commissioners and the personnel of the whole hospital system mourn the loss of a co-worker of keen sympathies, rare personal charm, and virile character whose genius greatly promoted the efficiency of the service and the welfare of the patients over a period of more than 30 years; therefore be it

Resolved, That the Commissioners hereby record their sorrow and sense of deep personal bereavement in Dr. Heyman's death. He was taken from us while in the zenith of his professional career, his health being broken by his conscientious devotion to duty. He had spared neither time nor physical energy in ministering to the needs of the patients committed to his care. And be it further

Resolved, That the Commissioners hereby convey their sincere sympathy to the members of Dr. Heyman's family and to the Board of Managers of Manhattan State Hospital, and be it further

Resolved, That the Commission hereby directs that these resolutions be spread upon its minutes and that copies thereof be transmitted to the bereaved family and to the Board of Managers of Manhattan State Hospital.

The Board of Managers of the Manhattan State Hospital, at a special meeting held Thursday, October 8, 1925, adopted a minute which was spread upon the records of the Board appreciative of his services to the hospital and the State.

The medical staff adopted a tribute of respect and affection at a meeting held the same day as did also the nurses and other hospital employees.

HENRY C. EYMAN, M. D.

Dr. Henry C. Eyman was born in Fairfield County, Ohio, April 13, 1856. His early education was obtained at Fairfield Union Academy. After completing the course at that institution he taught school for several years, and then entered the Columbus Medical College, graduating in 1880.

His first location for practice was in Tarlton, Pickaway County, Ohio, where failing health forced him out of practice. He then for a time conducted a drug store in conjunction with his brother in Lancaster, Ohio.

In 1884, he was appointed Assistant Physician at the Athens State Hospital. In July, 1887, he was appointed Assistant Superintendent of the Toledo State Hospital, a new institution at that time.

On August 6, 1891, he was made Superintendent of Cleveland State Hospital. He remained at the head of that institution until he was unanimously called to the Superintendency of the Massillon State Hospital, to succeed Dr. Richardson, who had been elected to preside over St. Elizabeth's at Washington. The responsibility of construction of this large hospital, one of the first of its kind on the cottage plan, fell upon him. He remained at its head until November, 1918, when, owing to ill health, he was forced to retire.

Under Dr. Eyman's régime at Cleveland, the last of the mechanical means of restraint were abolished. Dr. Eyman had been edu-

cated in the school of non-restraint under Drs. Richardson and Tobey, consequently these almost mediaeval means of controlling the insane were quickly abandoned and diversion, occupation and recreation substituted.

Dr. Eyman was for 12 years Professor of Nervous and Mental Diseases in the Cleveland College of Physicians and Surgeons, Secretary The American Psychiatric Association, 1915-18, President in 1919-20, a member of the American Medical Association, and honorary member of Canton Medical Society.

He was the author of many monographs and a voluminous reader.

Dr. Eyman was the son of Henry B. and Mary Baker Eyman, coming of a family of Ohioans since Revolutionary days.

Dr. Eyman was married September 12, 1880, to Miss Lestia Dern. Mrs. Eyman died October 21, 1908, at Massillon. Two daughters survive this union.

Dr. Eyman's health had not been good for several years, and on several occasions during the last five years he was seriously ill, but he maintained a cheerful manner and met his sufferings with calmness and fortitude.

He died October 7, 1925, at his residence in Massillon, Ohio.

He was an executive of much ability; he had his heart in his work and was filled with enthusiasm for the amelioration of human suffering.

His manner was gentle, yet he commonly carried his point.

His life was an inspiration, and the charm of his genial presence will always be a cherished memory.

JOHN D. O'BRIEN, M. D.